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THE JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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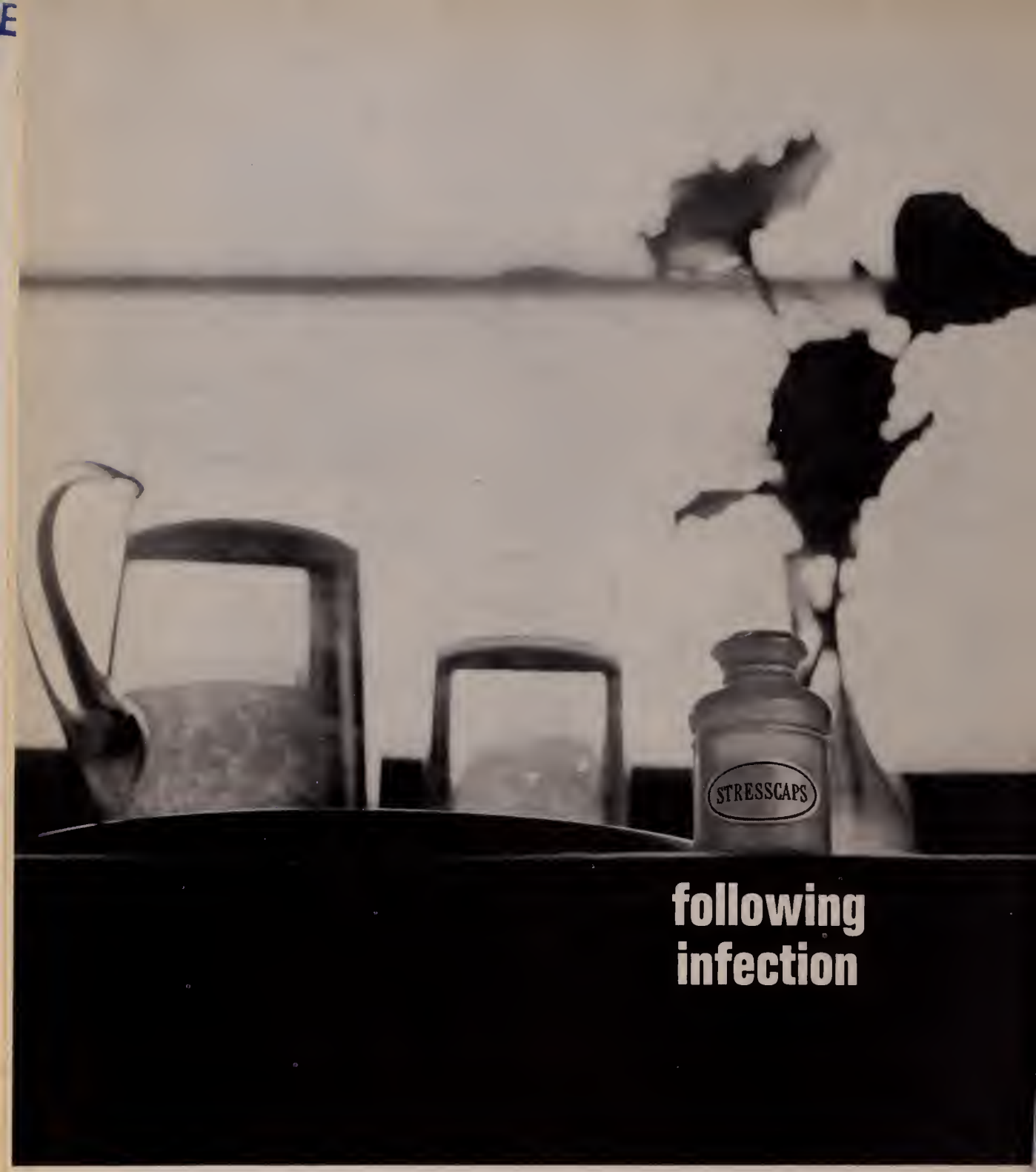
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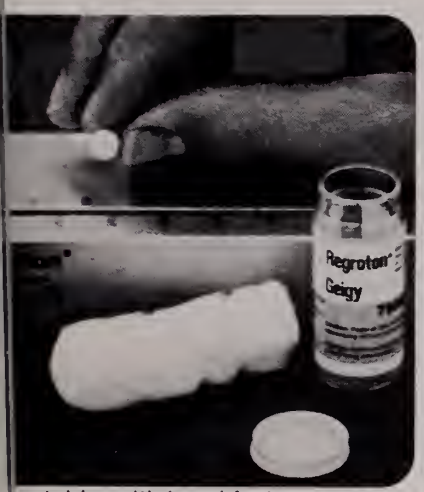
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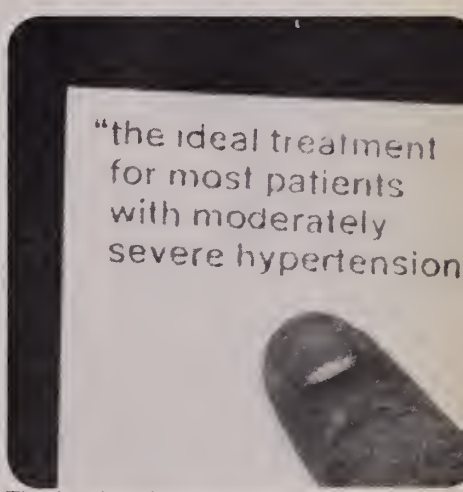
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1. Kunin, C. M. et al.: J. Clin. Invest. 38:1950, Nov., 1959.

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1. Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. 2. Weller, C. et al.: Scientific Exhibit, A.M.A., June, 1962. 3 Moss, J. M. et al.: Medical Times 92:645, 1964.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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Zigmond Lebensahn, M.D., Chief, Dept. of Psychiatry, Sibley Memorial Hospital, Washington, D. C.

William Sheeley, M.D., Director of Psychiatry & Medical Practice Project of the A.P.A., Washington, D. C.

Philip Solomon, M.D., Chairman, A.P.A. Committee on Medical Practice, Boston, Mass.

Course will be given at Jung Hotel, 1500 Canal Street, New Orleans, La. Hotel reservations to be made directly with the Jung or hotel of your choice. Registrants who would like to enjoy Mardi Gras (March 2) are urged to make hotel reservations immediately.

Guest speaker for the luncheon on March 4 will be George Burch, M.D., Henderson Professor and Chairman, Dept. of Medicine, Tulane Medical School. Subject: "Emotions and Cardiovascular Disease." Cost of luncheon included in registration fee. At the end of Friday's session, there will be a dutch treat two-hour cocktail party with George Lewis and his band from Preservation Hall entertaining.

AMONG TOPICS TO BE DISCUSSED:
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"Medical Practitioners and Supportive Handling of Schizophrenia"
"Adolescence—Disturbed and Disturbing"
"The Physician and His Reaction to the 'Crack' "
"Newer Thoughts About the Therapy of Alcoholism"
"Medical Conditians with Psychiatric Manifestations"
"Recognition and Treatment of Depressive Reactions by Medical Practitioners"
"Treatment of Emotional States by the Medical Practitioner"

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Division of Neurology & Psychiatry
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Enclosed is my registration fee of $20 for the "Psychiatry for the Medical Practitianer" course ta be given March 4-6, 1965, at the Jung Hotel. (Checks should be made payable to the Touro Infirmary.)

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1. Griffith, R. S., and Black, H. R.: Current Ther. Res., *6*:253, 1964.

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EDITORIALS

The Changing Face of Medical Practice

Thirty years ago, this country had 108 private practitioners to 100,000 American civilians; now the ratio is only 93*. Thirty years ago, only 2 per cent of the active M.D.'s (not in federal service) were not providing direct clinical service; now the figure is 8 per cent. These are some gross figures from recent studies,* which reflect the changing face of medical practice. In 1931, about 86 per cent of all M.D.'s were in private practice; now the figure is 63 per cent.

The most obvious changes in this profile are well known to all readers of this JOURNAL: more full-time specialists, more doctors in group practice, more in residency programs, more in hospital-based private practice, more on government foundation, industrial and research payrolls. Outside the federal government, the number of M.D.'s in full-time research, education, or administration has (believe it or not) sky-rocketted by 310 per cent in the past three decades. Less than twenty years ago, only 3 per cent of private practitioners were in group practice: now the ratio is 7¼ per cent. The federal government employs 22,000 physicians today. In 1931, the number was 3,500.

The significant change is not the growth of specialization, but the trend away from solo private practice. Specialists are, after all, clinicians, functioning on a one-to-one basis with patients. Regardless of their field, all privately practicing specialists have problems and attitudes in common. However, when a physician moves from solo private practice into a fulltime appointment in teaching, into a large practice group, into a salaried job in industry, foundations, hospitals, research, or government, he begins to make different identifications. The quality of his work in clinical and professional terms may not change—in some respects quality of work may improve, because of supervision by and responsibility to a senior practitioner or to a professional superior. It would be odious and inaccurate to make any value judgments one way or another in this area. But, the change is bound to affect the identifications of the physician, as well as the nature of the economic tie between doctor and patient which has so long flavored the traditional doctor-patient relationship.

Most of us look back with a wistful nostalgia on the old days when the practitioner discreetly negotiated fees with each patient, when he made his own decisions as to whether to charge at all, or to press for payment (in those days, credit ratings and collection agencies would have been considered professionally undignified), and when he selected the specialist to serve as his consultant. The nostalgia is understandable, but a decent respect for the facts of modern life requires us to see that those days are gone—probably forever. Our aim, after all, is to render first class medical care to fellow-human-beings; and in the pursuit of those aims, these modern trends can be a help rather than a hindrance. In the last analysis, this depends on us as individual practitioners.

Our Advertising Survey

Stitched into this JOURNAL is a return postcard. It looks like one more questionnaire. We don't blame you for groaning. However, this one is short and the results may be sweet. On your answers and on the adequacy of the reply sample depend one aspect of JOURNAL policy.

No State Society can operate a medical journal without selling advertising space. The information obtained through a survey like this will be swiftly translated into a better advertising operation, which in turn means that we can put out a better journal. As THE JOURNAL improves, the amount of advertising increases, so that we

*The figures in this editorial come largely from *Progress in Health Services* (University of Chicago Health Information Foundation) for June 1964. These, in turn, are derived from several AMA directories and reports for the years indicated, and from the *Health Manpower Source Book* of the U. S. Public Health Service.

can improve it still further. Also, in order for our readers to keep up to date, they have to know what's new in the field of pharmaceuticals, instruments, and professional services.

Please tear the card out now; check off your answers; and drop in the nearest mailbox.

Is This Speed Necessary?

"In no case," said the doctors concerned, "did excessive ambulance speed save a patient's life." A unique study, by Irma West, M.D. and others, was made for and reported to the California Department of Health and the California Highway Patrol. The survey covered the first six months of the year and limited itself to the ride back to the hospital, carrying the patient. Much of the information came from the ambulance drivers themselves. Injuries and apparent heart attacks accounted (between them) for two-thirds of all ambulance calls. In 11 per cent of the cases, patients were bleeding when the ambulance arrived, and in 10 per cent, they had dyspnea. No other morbid condition accounted for more than 7 per cent. In the opinion of the driver, 88 per cent of the calls were legitimately for "genuine emergencies", but the attending physicians placed only 58 per cent in that category. The commonest reason for the discrepancy was the driver's tendency to attach the "urgent emergency" label to emotional problems, which physicians generally viewed less excitedly. Many of the cases, however, must have been real emergencies, since one patient in four died of the accident or illness which led to the ambulance call. (Heart patients accounted for most of the deaths.)

The survey made a careful study of ambulance rides which exceeded the speed limit, and found that the median figure for time-saved by exceeding the speed limit was (believe it or not) less than 2 minutes. In more than a half of the runs exceeding the speed limit, the excess was by more than 10 miles an hour over the limit. The drivers thought that this speed saved the lives of three of 50 patients; but the doctors did not agree, and said that the true number was zero. However, 4 patients, in the opinion of the physicians, were benefitted by the excessive speed—and three of these were poisoning cases.

Sixty-one ambulance accidents occurred in the period studied—with 13 severe injuries and one death. The one killed was the patient, but most of those injured in ambulance accidents were passengers acting as escorts for the patient, or members of the ambulance crew.

Physicians commented favorably on how well trained the ambulance staff generally was and on the swift and superior service they provided. There was prompt and effective use of oxygen, pressure bandages, and resuscitators.

Scrutiny of all patients who died while being transported, or shortly after admission, revealed that in these cases "there had been no chance of survival through any additional first aid, or more hurried ambulance transportation".

It is concluded that the time saved by exceeding the speed limit is rarely of any benefit to the patient. One unexpected finding was that the few patients who did benefit by extra speed were poisoning victims, and that this was the one area where the ambulance crews were not well informed or well trained.

The impelling siren, the flashing light, and the clanging bell are old, and honorable parts of city life, but more often than not, their value is more for dramatic effect than for medical necessity.

ORIGINAL ARTICLES

By meticulously weighing all the possibilities, the peripheral vascular surgeon may find a way of salvaging the limb with occlusive vascular disease.

Indications for Surgery In Arteriosclerotic Occlusive Disease*

Gustave Suffness, M.D./Elizabeth

Years ago the almost routine treatment of peripheral vascular occlusive disease was above the knee amputation for necrosis or limited degrees of gangrene. Now, we aim at saving the limb by restoring the patency of a major artery by surgical means. Below knee amputations, transmetatarsal amputations, digit amputations, and spontaneous sloughs of necroses of the foot have all been made possible by increasing the arterial blood flow with successful surgery upon the occluded artery proximal to the affected site. Not always must the distal arterial tree be patent, and in selected cases the results have been encouraging. It is unfortunate that there is still so prevalent a feeling that an above knee amputation should be done without giving adequate consideration to the problem. Regardless of size, any lesion of a lower extremity with ischemia must be considered as a possible forerunner of a major amputation if there is no improvement with conservative therapy over a short period of time. Intractable pain with no external lesion must be placed in the same category.

The economic and social liabilities of amputees (or non healing lesions) are great. Because there will be so many more of these vascular patients in the future, the surgical restoration of the circulation must always be kept in mind. There has been great progress in vascular surgery in the past decade, and we can expect more. Many of these problems which had long seemed hopeless can now be approached with less pessimism.

We are usually concerned with older patients who have stenotic and/or occlusive atherosclerotic processes of the lower extremity's arterial tree. Many of these patients have a diabetes mellitus under various degrees of control. Meticulous history-taking and careful examination may disclose cardiovascular, renal, cerebral, or other serious disease. Rest pain and the degree of intermittent claudication are important in the discussion. Where is the claudication? Is it of long standing, progressively getting worse, bilateral, and is it vocationally disabling? How long does it take the claudication to disappear with rest, and how much further can the subject walk after the rest period? Detailed physical examination (particularly noting the peripheral pulses) is important. This is time consuming, and when routine, can be most revealing when the pulses of the upper, lower extremities, and carotids are sought and evaluated. Color changes of the feet with elevation and dependency, and temperature changes are of significance. The prospecting stethoscope has its value in our evaluation and may be highly enlightening in localizing stenoses of the peripheral vessels over which bruits may be heard. Many patients with an arterial stenosis due to atherosclerosis have a well marked systolic murmur over the site of the narrowing.

Great strides have been made in recent years in angiography. If and when it is deemed necessary to consider angioplasty in the occlusive arterial problem, as thorough a radiologic investigation of the arterial tree as is possible should be made. The radio-opaque

*Read at the annual meeting of The Medical Society of New Jersey, May 18, 1964.

material required to visualize the proximal and distal arterial tree must be carefully considered. This requires an interested and competent radiologic department. Future improvements in technics and equipment to give us needed information will be of inestimable help in selecting patients for surgery.

The vascular surgeon must give serious thought to the proper procedure whether it be endarterectomy (with or without a patch graft), resection and graft replacement, or a bypass graft. He must first decide whether the incapacity caused by the lesion is serious enough to warrant the risk, expense, and inconvenience of surgical correction. Can he prevent a major amputation in the instance of a necrosis or nonhealing ulceration, or relieve an acute severe ischemia by his procedure? Also, can he give hope to a patient with an economically disabling intermittent claudication? These are questions he must ask of himself.

It may be preferable to reduce the patient's activity to fit the available circulation rather than attempt an operative improvement of the blood flow. Not all patients with ischemia due to chronic occlusive arterial disease will develop gangrene and require amputation. Many patients equate their circulatory disease with disaster. It is necessary to assure them that very few will have to change employment because of their limited exercise tolerance. Unfortunately, too many physicians take a fatalistic view when major arterial closure has been demonstrated to them, and will express this to the patient or family. On the other hand, when collateral vessels are prominently demonstrated with angiography, only too often many physicians will become overly optimistic.

With proper foot care, relatively few will develop necrosis or ulcerations. Under conservative management, it is frequently observed that no longer will a patient complain of limb claudication when an angina pectoris of effort is superimposed and restricts their walking activity first. Unfortunately, the incidence of fatal cerebral or coronary accidents is high in those with peripheral arteriosclerosis obliterans. At the onset of conservative therapy, most patients will show improvement, and during this period many will adjust and manage well enough. Of course, there are those who become disappointed when the magic pill, or ointment, or physical therapy outline has failed to restore quickly their walking ability, warmed their feet, removed the rest pain, or healed a lesion. Often the apprehension is out of proportion to the gravity of the disease, and the dim view is so prominent that helpful suggestions from the physician are not carried out. These patients will continue to smoke, eat, and behave as they see fit rather than follow the suggested routine. We must be careful (especially in the diabetic with neuropathy) in differentiating the symptomatology due to the arterial occlusive disease and the neurologic pathology. Very often the major limb vessels are not seriously affected in the diabetic; instead the symptoms in the extremity are neuropathic in origin.

Conservative therapy includes the details of foot care outlined and carefully explained repeatedly. It is a phase of behavior which the patient should adhere to indefinitely. When seen in the clinic or office, questioning often reveals deviation from the rules, and explanatory encouragement is necessary over and over again. In this manner, a way of life is established. Even though surgery may be successful, the underlying generalized atherosclerosis is ever present.

There is considerable controversy regarding the so-called vasodilating drugs. Most investigators feel that the walking distance (in patients with intermittent claudication) is unaffected by available vasodilators. And some fear that an orally administered vasodilating medication will actually deprive needy tissues of blood since the vasospasm is greatest in the vicinity of pain, and the blood is then shunted to other areas where the vasomotor tone is less. Intra-arterial injections of tolazoline hydrochloride and 20 per cent procaine hydrochloride may be of value, as may selective sympathetic blocks in relieving localized vasospasm. Reflex heat has an almost specific effect upon skin circulation without influencing muscle circulation. We must be very careful to avoid direct heat lest we produce burns and necroses. Ischemic tissues are unable to overcome the increased metabolic demands by increasing the blood flow suf-

ficiently, and a resultant destruction may occur. Written instructions should be given to all patients.

Lumbar sympathectomy may be considered in patients with chronic occlusive diseases due to atherosclerosis. This is almost never helpful where the chief problem is intermittent claudication. However it is used for patients with rest pain (with or without small lesions) with appreciable success. Testing for the potential blood flow in a humidity and temperature controlled environment and a posterior tibial nerve block ideally should precede a sympathectomy. The successful sloughing of necroses is most gratifying, and the removal is often (especially if there is a neuropathy) painless, even through a phalanx as an office procedure or at the bedside. Maceration of surrounding tissues by ointments or wet dressings should be avoided. Judicious use of normal saline irrigations or soaks at room temperatures or slightly above, and bland ointments may be helpful. Dry lesions need not be disturbed unless there is an underlying infection. The healing, generally, is a slow process and can try the patient's patience as well as the doctor's.

The further reduction of the circulation, which has been close to a critical level of viability and tolerance, by added occlusive atheroscleroses can be disastrous. This might lead to complete disability. Surgery must be urgently considered in many of these instances just as if an embolic closure had taken place.

Conclusion

Surgery, when anatomically possible, should be recommended in the ischemic limb for relentless rest pain, limited necroses, or non-healing ulceration, for the acute ischemias and for the severe intermittent claudications. The future will give us more data as to whether worthwhile benefits will occur in surgical reconstruction done at the first sign of occlusive disease. Surgery at this stage often is for relief of a stenosis of the artery, when distal damage has not been established. Will such surgery have any bearing on preventing occlusive atheroscleroses distal or proximal to the minimal lesion? Further experience will give the answer.

General Directions for Foot Care

1. Wash feet each night with neutral (face) soap and warm water.
2. Dry feet with a clean, soft rag *without* rubbing the skin.
3. Apply rubbing alcohol (70%) and allow the feet to dry thoroughly; then apply a liberal amount of vaseline or toilet lanolin and gently massage the skin of the feet.
4. Always keep your fect warm. Use woolen socks or wool-lined shoes in the winter and white cotton socks in warm weather. Use a clean pair of socks each day.
5. Use loose fitting bed socks instead of hot water bottles, electric heaters or any form of mechanical heating devices to feet and legs.
6. Wear properly fitting shoes and be particularly careful that they are not too tight. Use shoes made of soft leather—ask your doctor.
7. Cut your toe-nails only in very good light and only after your feet have been cleansed thoroughly. Cut the toe-nails straight across. It may be necessary to see a chiropodist.
8. Go to your *Doctor* at the first signs of a blister, infection of the toes, ingrowing toe-nail, or trouble with bunions, corns or callouses.
9. Drink at least 6 glasses of water each day.
10. Have some member of your family examine your feet at least once each week.
11. Eat plenty of green vegetables and fruit in an otherwise well-balanced, liberal diet, unless you have been ordered to follow some special diet. Ask your physician.
12. Try to walk ..... to ..... ft. ..... times per day. When pain starts, then stop and rest until pain is all gone. Resume walking until pain again starts. Do not walk when you have *pain*. Stay indoors if it is very warm or very cold or very wet weather.
13. Raise head of bed ..... inch blocks.

Important Things Not to Do

Do not cut your corns or callouses and do not use commercial corn remedies.

Do not wear circular garters; do not sit with your legs crossed and do not bandage feet tightly.

Do not walk on bare feet.

Do not use adhesive tape on skin of feet.

Do not wear metal arch supporters.

Do not use strong, antiseptic drugs on your feet. Particularly never use tincture of iodine, Lysol, Gresol or Carbolic Acid.

DO NOT USE TOBACCO IN ANY FORM: Circulation is further decreased by narrowing the vessels.

DO NOT SEEK YOUR NEIGHBOR'S ADVICE. CONSULT A PHYSICIAN.

970 Park Avenue

Duplications of parts of the GI tract (often styled as cysts or cystomas) are rare, but treatable. Dr. Clemente here reports an unusual and successfully managed case.

Duplications of the Gastro-Intestinal Tract*

Celestino Clemente, M.D./Glen Ridge

Duplications of the gastro-intestinal tract are known in the medical literature by many other names because of the variety of their locations and the different forms they may take. Terms such as mesenteric cyst, omental cyst, neuro-enteric cyst, enterocystoma, and lymphangioma may be found in the older literature describing lesions which were probably duplications.

These findings may occur at any level from the base of the tongue to the anal canal. They are most commonly found in the terminal ileum or in the chest, but only rarely in the duodenum as in the case here in reported. Gross[1] cites only 4 of 68 cases found in the duodenum over a period at 22 years at the Boston Children's Hospital. Our case is even more unusual because we were able to resect the lesion along with the adjacent duodenum. This is usually not possible because of the complicating anatomic factors. Duplications may be globular or tubular and may be multiple. They may communicate with the adjacent bowel. They sometimes involve two body cavaties so that a duplication in the chest may traverse the diaphragm and communicate with the stomach or small intestine. When they do not communicate with the alimentary lumen, they are filled with a clear fluid to form a cystic mass, but intestinal mucosa is usually recognizable in the cyst wall. Tubular duplications may extend along long segments of the gastro-intestinal tract. They may communicate with it only at the proximal end leading to a blind loop syndrome or at the distal end and/or at both. Those communicating at the distal end may remain asymptomatic for a lifetime or give rise to bleeding which is probably the most important clinical feature of these anomalies. The cystic ones may give rise to extrinsic pressure on the adjacent bowel or be a factor in intussusception.

Duplications in the chest rarely have attachments to the esophagus. They are often cystic and lined by gastric mucosa. Autodigestion and marked inflammation may occur causing dense adhesions around them. These can usually be removed, without great technical difficulty. Tubular ones may occur in the chest and communicate with the stomach, duodenum, or jejunum. These often give rise to gastrointestinal bleeding, and when symptomatic must be entirely removed from both body cavities to prevent recurrence or difficulty.

Duplications within the abdomen usually share a common blood supply with the adjacent bowel. They are usually situated at, or arise from, the mesenteric side of the intestine. Because of this, they usually cannot be removed without sacrificing adjacent bowel. When it *is* possible, this is the procedure of choice. Excision of the duplication with the adjacent intestine is the way most of these are handled surgically. Duodenal ones, however, are usually more safely treated by internal drainage. This may be accomplished by cutting a large window in the common wall between duodenum and

*Read April 27, 1963 at the Annual Symposium, United Hospital of Newark.

[1]Gross, R. E.: Surgery of Infancy and Childhood. Saunders, 1953, Philadelphia.

duplication or by doing a Roux-Y type of anastomosis between the duplication and a loop of jejunum. Tubular duplications which involve too much intestine for complete removal may be partly removed if they cause bleeding, and the bleeding site can be located, or if a blind pouch is present an opening, can be established between the distal end of the septum and the intestinal lumen.

Bremer[2], in 1944, suggested the most widely accepted theory to explain intra-abdominal duplications. He stated that the lumen of the gut in a 6-week-old embyro is occluded by rapidly proliferating epithelial cells. Vacuoles then form which later coalesce to form the normal lumen of the intestine. The lateral aberrant position of a vacuole may then presumably result in duplication. More recently Veeneklaas[3] reported that spinal deformities frequently coexist with duplications of the tract. This has led to a theory that these lesions may be due to persistance of the neuroenteric canal which is a communication arising from a notocordal bud and which connects the primitive ectodermal plate to the entoderm covering the yolk sac. The notocordal process later normally should become incorporated in the vertebral column. The location of duplication behind the main axis of the gastrointestinal tract and the often associated vertebral body defects in these cases supports the hypothesis that all duplications may arise from neuroenteric dysplasias.

Case Report

A male infant was first seen in the Pediatric Clinic of Babies' Hospital at 2 months of age, because of recurrent vomiting since birth. His birth weight was 6 pounds, 12 ounces. At 2 months he weighed 7 pounds 2 ounces. At that time a poorly defined mass was felt in the right upper quadrant of the abdomen. Blood count and sickle cell preparation were normal. Urinalysis showed eight to ten leucocytes per cubic millimeters. Enterococci were grown from a catheterized specimen. Blood urea nitrogen was 24. The child was placed on Similac® formula and spasmolytics, and scheduled for excetory urography. A few days later he was brought back to the Clinic for recurrent vomiting. This time a rounded cystic mass much larger than before was palpated in the right upper quadrant and the child was admitted. Intravenous pyelogram revealed a large abdominal mass but a normal right kidney slightly displaced laterally. Upper gastrointestinal x-rays showed that the stomach and duodenum were displaced upward and to the left by a large mass in the right upper quadrant of the abdomen. Compression of the duodenum was demonstrated (See figures 1 and 2). On the fourth hospital day, the abdomen was opened

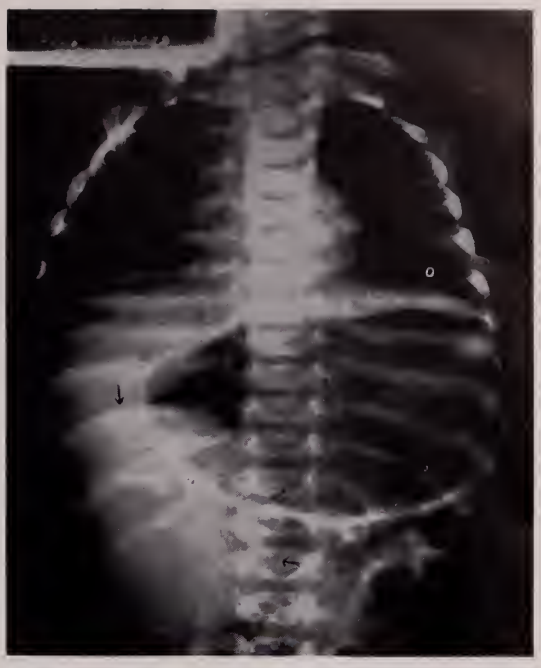


Figure 1. Intravenous Pyelogram showing right kidney slightly displaced to the right, a dilated stomach and a large globular mass in RUQ.

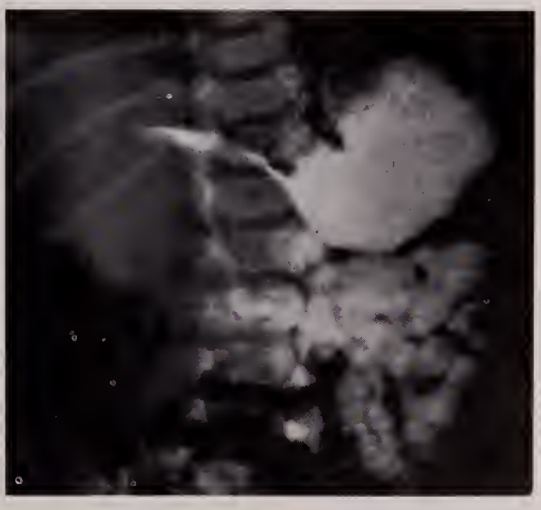


Figure 2. Gastrointestinal x-ray showing marked compression of duodenum by mass.

through a transverse incision and a large orange size mass presented in the right upper quadrant. The mass was filled with fluid and the wall was somewhat thick. It was loosely attached to the anterior surface of the pancreas and it was easily separated down to its attachment to the pyloric end of the stomach and first portion of the duodenum. The pyloric end of the stomach and first portion of the duodenum were resected with the mass, and end-to-end anastamosis was done reestablishing the continu-

[2]Bremer, J. L.: Arch. Path. 38:132 (1944)
[3]Veeneklaas, G. M. H.: American Journal, Diseases of Children, 83:500 (1953)



Figure 3. Excised specimen with a probe through lumen of adjacent duodenum.

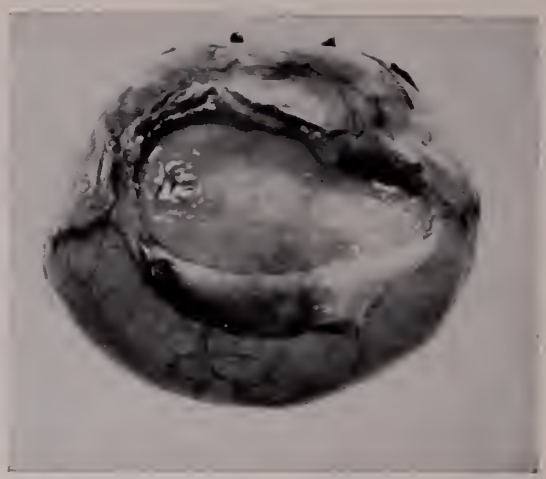


Figure 4. Excised mass with duodenum opened longitudinally.

ity of the bowel. The post-operation course was uneventful and the child was discharged from the hospital in good condition (See figures 3 and 4). The cyst measured 11 by 9 by 6.5 centimeters. It contained a colorless fluid. Microscopic examination of the cyst wall revealed a compressed mucosal lining with the glands in the lamina propria resembling those of the Brunner type.

Summary

Many lesions known in the past by several other names have come to be recognized as duplications of the gastrointestinal tract. These may be globular or tubular occurring anywhere from the base of the tongue to the anal canal. Clinically, they may be manifested by bleeding, the presence of masses, blind loop syndrome and even intussusception. Most duplications can be treated by excision along with the adjacent bowel, but where anatomic factors prevent this some method of internal drainage must be devised to relieve symptoms. An unusual case of duodenal duplication in a two-month-old infant successfully treated is reported.

364 Ridgewood Avenue

Calling All Calorie Counters

You don't need 3200 calories a day (as you did in 1958). Now you need only 2900. This bad news is relayed to us by the American Medical Association, which finds it in a release from the National Academy of Sciences. Reason for the reduced ceiling on calories: we are leading softer lives, with less physical activity. Practically nobody even walks to the corner grocery or newspaper store any more. Even golf players now ride on wheels. So the calorie requirement of the "average reference man"—25 years old, 145 pounds, and moderately active—was cut to 2,900 calories daily from the 3,200-calorie diet recommended in 1958. The recommended diet of the average "reference woman"—25 years old, weighs 128 pounds, and moderately active—was reduced to a 2,100 calories per day from the 2,300 calories of 1958.

The recommended daily consumption of the nutrients thiamin, niacin, and riboflavin also was cut.

The new revision included alcohol for the first time in the consideration of nutrients. The Board estimated that Americans, on a per capita basis, consume 76 calories of alcohol per day. This estimate includes children and other non-users, and the average consumption of drinking adults is much higher.

In the opinion of these investigators, a modified electrolytic technic is still the best way of getting rid of unwanted hair.

Hirsutism and Electrolysis*

H. C. Goldberg, M.D./Plainfield
S. L. Hanfling, M.D./East Orange

Hirsutism (or hypertrichosis) of any but the mildest type presents a major cosmetic problem to the present day woman. In fact, only hair-loss bothers her more. "Hirsutism," writes Hamblen[1], "describes an excessive growth of general body hair, which may or may not be characterized by android accentuation and which, accordingly, may or may not be coexistant with virilism or virilization."

Our own findings are that a small proportion of the women who come to us for help really have an amount of hair that we might more familiarly call hairiness. Our cultural and social customs picture a smooth skinned female; yet, actually, fine lanugo hairs (interspersed with heavy hairs) in a variety of densities and locations constitute the correct picture.

The true image and the projected one need the light of facts. "Man," says Montagna[10], "may be considered as a naked mammal except for purposeless hummocks of hair in odd and peculiar places with unusual visual and physical effects." Any not readily explainable sudden or gradual alteration in the quantity or location of hair should be carefully investigated.

Laboratory Tests

Research has produced new biochemical tests which are an aid in helping to classify hirsute disorders, many of which had previously been considered as idiopathic. Laboratory studies require highly specialized facilities to offer real help in this problem. Traditional standards for abnormal endocrinologic findings have changed markedly over the past few years. Although new tests have been found, only slight advancements to help understand and/or correct this problem have resulted. Dorfman[2] sums up the status of the laboratory studies as follows:

". . . The difficulty is an elevated plasma level of testosterone. Under abnormal conditions, the ovary may secrete sufficient highly active testosterone to produce hirsutism, or even virilism. Extra testosterone so produced may be so small in quantity as to not necessarily significantly increase urinary or blood 17-ketosteroids. Under these conditions, plasma testosterone and urinary testosterone levels are significantly increased."

Classification

A good working classification is that of Greenblatt.[3] Its main features may be outlined as follows:

I. Genetic Hirsutism
   A. Racial or familial tendency
   B. Individual predisposition (sensitivity)

II. Adrenal Hirsutism
   A. Cushing's syndrome
   B. Congenital adrenal hyperplasia
   C. Delayed onset congenital adrenal hyperplasia
   D. Borderline adrenal dysfunction
   E. Virilizing adrenal tumors
   F. Polycystic ovary syndrome with adrenal component.

III. Ovarian Hirsutism
   A. Stein-Leventhal syndrome
   B. Virilizing ovarian tumors
   C. (1) arrhenoblastoma
      (2) adrenal rest tumor
      (3) hilus cell tumor

IV. Hirsutism with sexual abnormalities.
   A. Male pseudohermaphroditism
   B. Gonadal dysgenesis with androgenic manifestations

V. Miscellaneous Hirsutism.
   A. Iatrogenic
   B. Achard—Thiers syndrome
   C. Porphyria

*Read May 20, 1964 at Atlantic City at the Annual Meeting of The Medical Society of New Jersey.

I. Genetic Hirsutism

A. *Racial or familial tendency.* This makes up the largest group of hirsutism in women. Most of these were originally believed to be idiopathic or familial. It is most frequently seen[4] in women of Mediterranean origin.

B. *Individual Predisposition.* The sensitivity of the female hair-follicle to the hirsutism inducing effects of naturally produced androgens[5] is a variable one. It is impossible to predict at what androgenic level hirsutism will develop. This response to variations in an individual's normal but variable androgen level must always be kept in mind.

II. Adrenal Hirsutism

A. *Cushing's Syndrome.* If the excessive hormones are of the hydrocortisone type (as in adrenal cortical hyperfunction) we have Cushing's syndrome. This accounts for less than 10 per cent of the cases showing prominent hirsutism. It is characterized by hirsutism, muscular weakness, atrophy of the genitalia and breasts, amenorrhea, "moon face," obesity, insulin resistant diabetes, hypertension, abdominal striae, and oily, acne-involved skin.

B. *Congenital adrenal hyperplasia.* Hirsutism is regularly seen in the adreno-genital syndrome along with virilism, an enlarged clitoris, increased muscular development, amenorrhea, absent or atrophic breasts, and male-type baldness. The excessive testosterone-like hormone is secreted by either a tumor or hyperplasia of the adrenal cortex and takes place *in utero.* The female child is born with ambiguous external genitalia. In more severe cases, its sex may be misdiagnosed.

C. Delayed onset congenital adrenal hyperplasia. Here the clinical evidences of virilization develop later and present no difficulty in sex differentiation, since the normal sexual characteristics are already formed.

D. *Borderline adrenal dysfunction.* Resembling the Stein-Leventhal syndrome, but not responding to the classic ovarian wedge resection, are the group of borderline adrenal dysfunction cases. These show hirsutism, clitoral hypertrophy, menstrual disturbances and sterility. Although not helped by surgery, they often respond to adrenal steroid therapy.

E. *Virilizing adrenal tumors.* These may, or may not, be malignant. Clinical manifestations depend upon the amount and type of hormones secreted and the age of onset. In the young female, although there is a premature appear-

DIFFERENTIAL DIAGNOSIS OF STEIN-LEVENTHAL SYNDROME

	STEIN-LEVENTHAL SYNDROME	ACHARO-THIERS SYNDROME	CUSHING'S SYNDROME	CONGENITAL ADRENOGENITAL SYNDROME IN THE ADULT FEMALE	ACQUIRED ADRENOGENITAL SYNDROME IN THE ADULT FEMALE
STATURE	NORMAL	NORMAL	NORMAL	SHORT	NORMAL
OBESITY	GENERALIZED	GENERALIZED	LIMITED TO FACE AND TRUNK	—	—
DIABETES	--	PRESENT	USUALLY PRESENT	—	—
HYPERTENSION	--	FREQUENT	FREQUENT	--	--
HIRSUTISM	MILD TO SEVERE	MILD	MILD	SEVERE	SEVERE
MENSTRUAL DISORDERS	USUALLY FUNCTIONAL AMENORRHEA	USUALLY OLIGOMENORRHEA	USUALLY OLIGOMENORRHEA	PRIMARY AMENORRHEA	SECONDARY AMENORRHEA
EXTERNAL GENITALIA	CLITORIS ENLARGED RARELY	CLITORIS SOMETIMES ENLARGED	CLITORIS ENLARGED RARELY	INTERSEXUAL GENITALIA	CLITORIS CLEARLY ENLARGED
MUSCULAR SYSTEM	NORMAL	NORMAL	ATROPHIC	HYPERTROPHIC	HYPERTROPHIC
MOON FACE	ABSENT	ABSENT	PRESENT	ABSENT	ABSENT
PLETHORA	ABSENT	RARE	FREQUENT	ABSENT	ABSENT
STRIAE CUTANEA	WHITE TYPE	WHITE TYPE	PURPLISH TYPE	ABSENT	ABSENT
FRIABILITY OF CAPILLARIES	NORMAL	NORMAL	INCREASED	NORMAL	NORMAL
WEAKNESS	--	--	YES	--	--
OSTEOPOROSIS	--	--	YES	--	--
EDEMA	--	--	OCCASIONALLY	--	--
PSYCHIC SYMPTOMS	--	--	FREQUENT	--	--
EOSINOPHILS COUNT	NORMAL	USUALLY NORMAL	LESS THAN 100/CU. MM.	NORMAL	NORMAL
URINARY 17-KETOSTEROIDS	NORMAL OR SLIGHTLY ELEVATED	NORMAL OR SLIGHTLY ELEVATED	NORMAL OR SLIGHTLY ELEVATED	MARKEDLY ELEVATED	MARKEDLY ELEVATED
URINARY 17-OH-STEROIDS	NORMAL	NORMAL	ELEVATED	NORMAL	NORMAL
URINARY PREGNANTRIOL	NORMAL	NORMAL	NORMAL	ELEVATED	NORMAL

ance of genital hair, no abnormal hair growth is seen. In the adolescent, however, menstruation is delayed and there is an absence of breast development. Hirsutism is present. In the later years, female sex characteristics are replaced by secondary male sex characteristics. Hirsutism is a common problem.

F. *The polycystic ovary syndrome* associated with an adrenal component. This resembles the Stein-Leventhal syndrome, but it responds to adrenal steroid therapy. By first giving the patient a therapeutic trial by hormone therapy, surgery may be avoided.

III. Ovarian Hirsutism

A. *The Stein-Leventhal syndrome* is characterized by hirsutism, amenorrhea, obesity, sterility, and bilateral polycystic usually enlarged ovaries. Virilism is not present. The differential diagnosis of this and other forms of hirsutism as compiled by Greenbratt[6] is listed in the table.

B. *Virilizing ovarian tumors.* The commonest ovarian tumor causing hirsutism is the *arrhenoblastoma.* This also produces virilism, amenorrhea, an enlarged clitoris, acne, and occasionally a male voice change. Sometimes, we see an adrenal-rest tumor. When producing sufficient excess androgen-like hormone, this results in changes undistinguishable from those produced by the arrhenoblastoma. Finally, there is the *hilus cell* (or heydig cell) tumor, which produces virilizing changes similar to those seen in arrhenoblastoma.

IV. Hirsutism Associated with Sexual Abnormalities

A. *Male pseudohermaphroditism* occurs in an individual in whom there is normal genetic gonadal development but whose secondary sex characteristics are mixed. The syndrome is either transmitted through a sex-linked gene *via* the female; or is the result of the effect of feminizing abdominal testes. Hirsutism is a common symptom, along with changes in the secondary sexual characteristics.

B. *Gonadal dysgenesis* with androgenic manifestations is called Turner's syndrome. This is characterized by sexual infantilism which shows a number of variants. The androgenic manifestations are clitoral enlargement, hirsutism, android pelves, and negative nuclear sex chromatin patterns.

Finally, mention must be made of three miscellaneous rubrics: the iatrogenic, the Achard-Thiers syndrome, and the porphyrias.

A. *Iatrogenic.* Hirsutism may result from the use of medically prescribed drugs or physical therapy. It may occur with or without other signs of virilism. The effect is determined by the individual's hair follicle's sensitivity to the hirsutism-inducing effects of the drug or therapy. Since this varies, the effect cannot be predicted, but the possibility must always be kept in mind. The danger of producing unwanted hair must be considered whenever we prescribe androgens, "anabolic" steroids, or progestogens with androgenic side effects and combination mixtures including various hormones.

The *Achard-Thiers syndrome* is a questionable specific syndrome showing hirsutism, obesity, diabetes, and hypertension. (See the table.)

The porphyrias[7] may lead to a striking diffuse hypertrichosis including, at times, a downward growth of hair line over the forehead. Characteristic traumatic or light-produced blisters, plus a urine fluorescent under the Wood's light, are noted in some porphyrias.

Recommendation

The attending physician should investigate all cases of hirsutism. Begin with an accurate family and personal history and a meticulous physical examination. From here, proceed with indicated laboratory tests. Differentiate the types of hirsutism which may respond to suitable medical and/or surgical procedures.

Treatment

Seven methods have been described to correct the problem of unwanted hair. These are:

1. Oral cortico-steroid preparations (Perloff[8]). This has turned out to be a disappointing method.
2. Removal of hair by cutting with scissors, with an electric razor, or with a safety razor. This is a good technic, but there is tremendous patient-resistance to its application to the face,

as contrasted with its common use for removing hair on the legs.

3. Chemical depilatories to "dissolve" the hair.
4. Pull-out depilatories—usually in the form of a hard wax.
5. Abrasive (pumice-stone) types of depilatories.
6. Bleaching to make the hairs less noticeable.
7. Electrolysis.

Electrolysis

Electrolysis is the only permanent physical modality available. It needs considerable improvement. To this end, we shall offer several suggestions and ideas. The entire procedure is confused, partly because the largest part of these treatments is carried out in commercial establishments such as department stores and in beauty salons, and by independent, poorly controlled operators. The public is barraged with a steady stream of extravagent claims from these sources. The dermatologist has gradually grown tired of using a tedious, unrewarding procedure whose results cannot meet public expectations. We propose to vitalize and reawaken his interest in this field. "The problem in this field is not so much a lack of knowledge as in knowing so many things that just ain't so."[11]

Electrolysis is a general term for the removal of hair by various electrical methods. Originally, it meant removal by galvanic current only. In 1879 Michel[12] introduced electrolysis by the galvanic current for the permanent removal of hair. The method spread rapidly in this country. To a large extent, economic conditions, social customs, and criteria for beauty determine its use. Probably no other country uses electrolysis as extensively as it is used in the United States. Improvements in the types of electrolytic currents have steadily grown. The galvanic current is falling into disuse, however, because it is slow compared with newer methods.

Spark-gap current destroys tissue by a spark. It is very fast. The more popular short-wave or radio-frequency type currents now available can destroy tissue without the use of an actual spark.

Ellis[9] published an account of the histologic changes in tissue so treated. He noted considerable difficulty in finding the track of the needle because the changes produced in the tissues were not prominent. Our own early studies of tissue reactions showed how difficult it is to follow the effects of the electrolysis treatments. This has been partly overcome in our later experimental studies by dipping the electrolysis needle into india ink. After insertion into the skin, the track of the needle is more readily found.

The pathologists† of the Muhlenberg Hospital have been most helpful in interpreting the histologic changes in the tissues created by electrical methods. These changes include alterations in the cell borders of the epidermal and dermal tissues, the development of pyknotic nuclei, and changes in the appearance of the collagen tissues. It is remarkable how few changes are observed with the amount of current ordinarily tolerated by the patient. Some of our work was done on skin anesthetized with procaine. Even in these areas (using considerably stronger currents and longer periods of time) no severe destruction of tissue was noticed. This is probably because even this "stronger range" is not a highly destructive one. Furthermore, our body tissues are "wet" and this condition rapidly dissipates the effects of these currents.

The use of *wax* to help control unwanted hair has been found most helpful to one of us (H. C. G.). We have heard the allegation that this distorts the hair follicle (making it more difficult to treat later). We do not feel that this is a valid objection. It is a good method used either *alone* or *in conjunction* with electrolysis to improve the appearance of the face and other areas of the body.

Many *technical factors* are involved in the electrolysis procedure. Assuming a good machine is used and a good technic is followed, we see two difficulties:

1. Difficulty in placing the needle at the effective spot (the hair root).
2. For the patient to tolerate a current strong enough for adequate destruction of the hair bulb.

To paraphrase a familiar expression, "a hair root is as difficult to kill as a possum." The oc-

†We wish to express our appreciation to the pathologists of the Muhlenberg Hospital for their help.

casional effort to destroy a single isolated hair with anesthesia and with strong currents has frequently been a failure. This points up the inherent difficulties of doing effective work under the usual working conditions.

First let us discuss the difficulty in placing the needle in an effective position to destroy the hair root. We have been taught that a fine needle with a rounded tip can be gently passed through the follicle pore opening down within the external hair follicle sheath, to rest against the hair root. In this ideal position the current is then applied and destroys the hair root. This is a pretty theory. The fact, however, is that in many tissue sections which we have examined, we did not find evidence that the needle follows such a path. It often came *near* the root of the hair that is being treated, *or of an adjacent hair root.* If it is close enough and if the current (strength times seconds) is strong enough, that hair root will be permanently destroyed. The strength of the current depends mostly on the pain tolerance of the patient. Usually this does not permit a current adequate to give a high scoring record in the proportion of hair roots destroyed.

A current strong enough to destroy a high proportion of the hair roots treated may also cause undesirable skin changes. These skin changes have encouraged some dermatologists to return to the milder original galvanic type machine. Procaine or other subcutaneously injected drugs are the only effective agents for anesthesia. If caution is used to avoid skin damage due to excessively strong currents, this has a limited place in such therapy. Hypnosis has seldom been used to block pain and discomfort in this procedure, although it might seem to be effective for this purpose.

The best way to protect the skin itself against damage by the current is to use an insulated needle. These have been used for 30 or more years. The idea is to protect the skin surface while permitting more extensive and effective destruction below it at the site of the hair root. As with most new ideas, this one has gone through many improvements. Until recently, insulated needles have not been practical; but effective improvements in this direction are being worked out.

Experimental Technics

Three experimental procedures that we have used will be of interest.

1. We found the electrical currents to affect tissue along the entire shaft of the needle, contrary to other ideas on this subject. We satisfied ourselves on this by a technic which may be described as a "slide-view" test. The electrolysis needle (connected to a suitable machine) is placed on a piece of meat and covered with a glass slide. Resulting distribution and the amount of destruction of the tissue when the current is turned on is then readily viewed.

2. Another experiment was used to determine whether the hair is anchored only at the root or also along the hair shaft or both. After punching out hair bearing sections of skin, the portion containing the hair root was cut off. It was then found that the hairs could be slid out of the skin effortlessly. This demonstrated that the firm attachment of the hair is at the hair root.

3. The roots are easily exposed for experimental purposes by removing a plug of hair-bearing skin. The roots can then be accurately visualized and treated with an electrolysis needle in a variety of ways. The treated hairy plug is then replaced and observed for regrowth of the treated and epilated hairs.

Conclusion

1. Electrolysis has been a slow tedious modality in the treatment of hirsutism. Its advantages need to be clarified and further improvements in technic need to be sought to make it more practical and more effective.

2. Our results over a period of over twenty years show this "permanent method" to be the best available but far from an ideal method so far as the actual destruction of hairs is concerned for reasons given.

3. Electrolysis has been gratefully accepted by the average woman as a way to overcome unwanted hairs. Unfortunately, erroneous ideas and feelings about hairiness have built up an incorrect idea of what the normal and wide range of hair distribution really is. We hope to have brought back to a sensible proportion the correct physiologic picture of hair destruction. The female may still wish to remove unwanted hair, but she will know why and we hope to know how.

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7 Watchung Avenue (Dr. Goldberg)

What's Ahead In the Academy of Medicine

The Academy of Medicine of New Jersey (located in Bloomfield) announces the following programs for early 1965:

January 13, at 12 noon, a presentation on Chest Roentgenology at the B. S. Pollak Hospital, 100 Clifton Place, Jersey City.

January 13, all afternoon, starting at 2 p.m., a scries of papers on managing the Crippled Lung. This colloquium will be held at the Middlesex General Hospital, 180 Somerset Street in New Brunswick. Inhalation therapy equipment will be demonstrated during this meeting.

January 21, from 4:30 to 6 p.m., a session on congenital heart disease will be held at the Somerset Hospital which is at 14 Rehill Avenue in Somerville.

March 17, all day—from 8:15 a.m. to 6 p.m.—a veritable graduatc course in gastroenterology at the Mountainside Hospital on Bay Avenue (corner Highland Avenue), Glen Ridge, just east of the Montclair line.

For details, 'phone the Academy at PI 8-0544; or write to the Academy of Medicine, 307 Belleville Avenue, Bloomfield.

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Richard I. Nevin, Executive Director
The Medical Society of New Jersey

In these few pages, Dr. Rubin has packed a veritable monograph on the treatment of strabismus in children.

Pre-operative and Post-operative Management of Eso-Deviations*

William Rubin, M.D./New Brunswick

If the trend to recognize and treat strabismus earlier and earlier persists, its pre-operative management will be limited to very brief investigations, occlusive, cycloplegic or miotic therapy.

Examination of the infant with strabismus consists of:

(1) approximation of the angle of deviation by the Hirschberg method.
(2) observation of vergences and conjugate movements in all fields of gaze.
(3) retinoscopy and ophthalmoscopy under atropine cycloplegia (0.5 per cent).

If the doctor is unable to gain a good view of macula with the ophthalmoscope or if he cannot do retinoscopy because of the child's vigorous objections, these examinations should then be done under general anesthesia.

Where there is alternate fixation, it might also be advisable to plan the necessary muscle surgery at this time if fundus examinations are normal.

If the eso-deviation is intermittent and accommodative, miotics may be helpful in maintaining parallelism. Glasses correcting the refractive error (especially where there is astigmatism and anisometropia) are of great importance in infants, even those who are under one year of age. Linksz[1] has well explained the mechanism of amblyopia in anisometropia. Where one eye fixes constantly, it is necessary to use atropine in that eye to encourage fixation with the opposite deviating eye. Once fixation can be switched, the atropine is discontinued. It must be remembered that occlusion for over 6 weeks of an infant under 6 months of age may induce amblyopia. Over one year of age, 6 months of occlusion are required to produce amblyopia. At the age of 5 years, it is difficult to create permanent amblyopia by patching.

If the atropine does not switch the fixation, total occlusion using an Elastoplast® patch directly over the eye is used. If glasses are worn, the so-called "sneak" occluder† may be attached to the lens. It is sometimes advisable to introduce the "sneak" occluder in lower density 20/30 or 20/50, increasing to 20/200 as it becomes acceptable. It is always wise to have the youngster return in 2, 3 or 4 weeks to observe progress and to keep the parents aware of the responsibility they have assumed.

Large angle eso-deviations should be corrected surgically as soon as a switch in fixation can be obtained. In older children one may be unable to secure such alternation before proceeding with surgery.

Once the child is over three years of age and is old enough to permit determination of the fixation pattern, we are presented with one of our most valuable findings in all strabismus evaluations. The visuscope has proved to be most useful both for determining fixation and for fundus examination (as an ophthalmoscope). Good detail is usually obtained, and the star in the center of the light is readily seen

*Read May 20, 1964 at the Annual Meeting of The Medical Society of New Jersey.

†Occlusive foils are obtained from Optiker Ryser in St. Gallen, Switzerland or from Omega Instrument Company at 207 East 37th Street in New York City.

by the patient even by one with eccentric fixation. To undertake surgery without knowing the fixation pattern is, to me, as inconceivable as to proceed with surgery without knowing the visual acuity when this is obtainable.

Once the child has reached 4 to 5 years of age, accurate measurements in the cardinal fields of gaze (including 25 degrees above and below the primary position) are made. The Worth four-dot test for fusion at distance and near and the after-image test for anomalous correspondence, preferably by use of an electronic flashing device, should also be done when possible. Stereopsis by the Wirt Test is routinely tested for when the child can give reliable responses.

The Bagolini[2] striated glass test is useful where little dissociation of the already unstable fusion status is found desirable. Bagolini[2] has made some interesting observations regarding a red filter of low density or a small prism as compared with a more dense filter or larger prism, producing suppression in the former or diplopia in the latter.

Where the angle of deviation is less than 10 prism diopters, reverse prism for the deviating eye and calibrated occlusion for the fixing eye is strongly recommended. Calibrated occlusion is furnished by means of plastic foils of varying density permitting 20/25 to 20/200 vision. Visual acuity in the deviating eye should not be less than 20/50 and fixation centric to parafoveal. Even if the eyes are not made parallel by this method, a month or so of this treatment often improves fixation and visual acuity in the deviating eye so that surgery will be more effective.

Although a number of aspects seem to enter into an explanation of this technic, Bagolini's paper[2] on the use of the filter bar as a dissociating instrument probably offers the most attractive discussion of these factors.

Another important work to appear recently on the effect of prisms is that of Harris[3] entitled "Adaptation to Displaced Vision; a Proprioceptive Change." He shows that Helmholtz's observations[4] on displacement of the visual field by prisms is an adaptive phenomenon best attributed to proprioceptive changes within the adapted hand. It would seem to me that such proprioceptive impulses must also come from the extrinsic ocular muscles and are mediated at cortical or subcortical levels.

In the child over 6 years of age with less than 20/50 vision and eccentric fixation in the deviating eye, pleoptics will be necessary. If the angle of deviation is over 10 prism diopters, the visual acuity under 20/50, and the fixation eccentric, reverse prism therapy is *not* recommended until both pleoptics and surgery have been provided. If the angle is over 25 prism diopters, surgery will need to precede pleoptics in order to permit proper use of the instruments. It must be emphasized that prolonged occlusion of the normal eye in cases of amblyopia with eccentric fixation may intensify the suppression and later make cure with pleoptics unattainable.

To explain these failures, one must realize that during occlusion the eccentric points used in fixation are suppressed but all other retinal areas are encouraged (actually compelled) to develop abnormal spatial relationships. This abnormality in spatial localization becomes so effectively facilitated as to defy any attempt at reversal.

It is difficult to state what is excessive occlusion of the normal eye. However, it would seem safe to continue patching the better eye as long as fixation and visual acuity improve. When these findings remain unchanged for one month, discontinue patching.

In all larger deviations with centric or near centric fixation and good visual acuity, surgery should be done promptly and repeated where necessary until parallelism is obtained or a small residual angle of deviation remains. It must be remembered that a small angle deviation, though cosmetically acceptable, is still a tropia. It may have an accommodative element and may be labeled monofixational esophoria; but it is still a squint with all the disadvantages associated with an absence of true single binocular vision. They have all gradations of peripheral fusion, can occasionally fuse foveal targets but rarely have useful depth perception. These cases often revert to lower visual acuity and larger angle eso- or exo-deviations.

Our results after treating 118 cases of small angle deviations with reverse prism have shown that 60 per cent could be made completely parallel. Four-fifths of the eccentric cases became centric. Of those in whom visual acuity could be obtained, 65 per cent improved 1 to 3 lines; 70 per cent improved or gained Number 3 on the Wirt Stereotest; and 15 per cent of the children required pleoptics.

Since more and more cases of small angle deviation are being discovered in routine screening, especially in those who have had surgery, our attention must be directed to their correction.

It has proved most comforting, particularly in the immediate post-operative period, in slight over or under-corrections to resort to reverse prism and calibrated occlusion, instead of to hopeful anticipation. The cost of a 5 prism diopter lens incorporated into the child's usual prescription, base-in or base-out as needed, is trivial compared to its potential value.

Once there is parallelism and some degree of fusion is obtained, simple orthoptics at the office and at home with stereoscope and orthofusor, or with the major amblyoscope at the orthoptic center is advisable.

In the immediate post-operative period where encouragement of convergence is desired, a convergence trainer consisting of a rotating spiral at adjustable distances made by Tuschka of Austria has been found helpful. They have also built a device useful in expanding the ocular muscle fields of rotation known as the muscle trainer. Both of these may be used by the fourth post-operative day for a period of 4 or 5 consecutive days.

Summary

1. The pre-operative management of eso-deviations is concerned mainly with achieving alternate fixation in the very young child by the use of atropine and various occlusive technics. Accurate refraction under cycloplegia is necessary in the battle against amblyopia.

2. Pleoptics at the present time is our only method for handling most types of amblyopia with eccentric fixation best tested for with the visuscope.

3. In the post-operative as well as pre-operative care of small eso-deviations, reverse prism with calibrated occlusion has offered new opportunity for securing true binocularity with useful depth perception.

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184 Livingston Avenue

Side Effects of New FDA Regulations

An important step to acquire new drugs with the utmost safety is the proposed independent "court of appeal" to review disputed F.D.A. decisions on the technical aspects of drug evaluation. For the regulations to insist upon drug safety and drug efficacy is unrealistic, since all life is a risk. Drug safety can never be guaranteed, and product efficacy is even more ephemeral. When government attempts to regulate private enterprise, whatever evils it hopes to correct are compound. The new F.D.A. rules, unless drastically modified, will increase drug prices, destroy the small pharmaceutical houses, hamper research, and thus greatly increase the number of untimely and unnecessary deaths.—F. P. Rhoades, M.D., in Michigan and Wayne County Academies of General Practice *Bulletin,* August 1963.

The fat boy and the fat girl are the subject of ridicule and personal unhappiness. They are usually poor diet followers. Dr. Fischman's study here suggests that good results can be achieved with an anorexiant.

Control of Obesity In Children

Mervin E. Fischman, M.D./Newark

Obesity in children, as in adults, is most often the simple end result of overeating combined with a reduced expenditure of energy. What causes this behavior pattern is a more complex problem.

Endocrine malfunction, if any, can be determined before any reducing regime is begun, and can then be treated. Familial habits of eating or ethnic ideals of health and beauty (favoring a full-blown figure) may occasionally lead to food excesses. More often, emotional problems are singled out as the prime cause of obesity. Paradoxically, I have often found that obesity, *in itself*, may be the cause of a child's emotional difficulties, particularly those experienced at school or with playmates.

Regardless of what causes the obesity, the child's caloric intake must be reduced. Since dietary restrictions alone are difficult to follow and often lead to further tensions and irritability, the use of an appetite depressant is an important part of the program. Though growing children cannot thrive on strictly reduced diets, most excessive weight gains in children occur from the extra calories consumed *between meals*. These snacks should be avoided without imposing restrictions at regular meals. An appetite depressant should, therefore, be given at midday so that its maximum effect will occur during the afternoon.

Among the oral anorexiants widely used over the past 10 years is phenmetrazine (Preludin®)*. This sympathomimetic amine belongs to the oxazine group of compounds. Early pharmacologic studies [1,3] confirmed by later clinical experience [4,18] have shown that phenmetrazine produces excellent results in appetite suppression and weight reduction with minimal central nervous system stimulation or other disturbing side effects. Published clinical studies in children [19,27] have been comparatively few, and with rare exceptions, [25,27] have been accompanied by rather rigid dietary restrictions.

The aims of this paper are (1) to describe a novel approach in the treatment of obese children, and (2) to demonstrate that phenmetrazine is well tolerated in children and is a highly effective appetite depressant, with no tendency towards habituation when given for a 6-month carefully supervised period.

Materials and Methods

The 51 children included in this study were selected over a period of four years from 200 children who came to my office for periodic examinations during which the parent requested that the child receive some type of treatment for overweight. Of the group of 200, I considered only 51 were cases of true obesity (25 per cent or more overweight) which might benefit from a reducing regimen. These 21 boys and 30 girls, ranging in age from 4 to 16 (Table 1), were started on phenmetrazine therapy after following preliminary procedures.

TABLE 1
AGE AND SEX OF PATIENTS

Age	Male	Female	Total
4-6	2	2	4
7-9	5	13	18
10-12	14	12	26
13-16	0	3	3
Total	21	30	51

*Preludin®, 2-phenyl-3-methyl-tetrahydro-1, 4-oxazine hydrochloride, brand of phenmetrazine hydrochloride, Geigy Pharmaceuticals, Ardsley, New York.

A detailed history was obtained, with particular reference to familial history of obesity and diabetes, and psychosomatic problems other than obesity. After a meticulous physical examination, including blood pressure and weight recordings, these four laboratory tests were done: urinalysis, complete blood count, protein-bound iodine, and 17-ketosteroid estimations.

Three children who had low 17-ketosteroid levels received a course of anterior pituitary-like (A.P.L.) medication before phenmetrazine was given; 4 with low protein-bound iodine levels received whole grain thyroid extract along with the phenmetrazine dosage. Vitamin supplements were prescribed for all the children.

On completion of the laboratory studies, a conference was held with the parent and the child to enlist their cooperation. I explained that the program of about six months' duration would in no way be similar to an adult obesity regime. After indicating the approximate weight I would like to see each child lose, I explained (particularly to those in the 9 to 13 age group) that every increment of an inch in height should normally signify a 3 to 5 pound increase in weight. If during the 6-month period, therefore, a child lost 4 pounds and grew one and a half inches, he really, in effect, would have lost 8 to 11 pounds. The parents were instructed *not* to put the children on rigid diets, but allow each child to eat three full meals a day, with only one limitation: no "repeats" in desserts. It was understood that my prime purpose in giving an appetite suppressant was not to diminish the appetite during mealtime, but *only during the between-meal periods*, particularly in the afternoon. At this time, they were told, food excesses far beyond normal caloric requirements cause most of the abnormal weight gains in children.

Accordingly, phenmetrazine would be taken once a day, after luncheon, so that the maximum effect might be attained during the afternoon when the children returned from school. It was also stressed that the drug would be given for only 6 months and then discontinued. The availability of phenmetrazine was carefully controlled. It was dispensed by me in the office to the parents with explicit directions as to dosage. No prescriptions were written.

Each child was present during the entire conversation, and was then questioned (with the exception of the four youngest, 4 to 6 years of age) as to any anxieties he might have about the procedure and also about his willingness to participate. All replied eagerly that they were ready to try the new regime.

TABLE 2
INITIAL DOSAGE OF PHENMETRAZINE, ACCORDING TO BODY WEIGHT*

Initial Weight (lb.)	Number of Patients	Daily Dosage 12.5 mg.	25-50 mg.
50-89	13	10	3
90-109	13	4	9
110 and over	25	2	23
Total	51	16	35

Dose

Initially, phenmetrazine dose was related to body weight which ranged from 53 to 173 pounds, with a mean of 106 for the entire group of 51 patients (Table 2). Sixteen children were started on 12.5 milligrams and 35 on 25 to 50 milligrams, once daily after lunch. After 3 weeks, each received an exhaustive examination including blood pressure and weight recordings. They and their parents were then questioned about side effects. If weight loss was satisfactory (3 pounds or more) and side effects absent, the dose remained the same. If side effects such as "nervousness," insomnia, or epigastric pain had occurred at the 12.5 milligram dose, the drug was discontinued. If weight loss was inadequate and side effects were absent, the dose was increased, usually by giving 12.5 or 25 milligrams, as indicated, after breakfast in addition to the after-lunch dose. Visits were then scheduled at 5-week intervals, and a similar procedure was followed at subsequent visits.

The program was planned for approximately 6 months, but for various reasons, duration of medication varied from one to twelve months. Most subjects were treated for from 3 to 6 months (Table 3). Some grossly overweight patients, treated for more than 6 months, stopped therapy for a few months and then resumed it.

*Weight range from 53 to 173 pounds, with a mean of 105.6 pounds.

TABLE 3
DURATION OF TREATMENT WITH PHENMETRAZINE

Duration	Number of Patients
Up to one month	1
1 to 2 months	3
3 to 4 months	9
5 to 6 months	21
7 to 12 months	17
Total	51

Eight of the 51 children who were uncooperative were excluded from the final evaluations. Although some of these 8 children did lose weight, they took their medication only sporadically or failed to keep their office appointments regularly.

Criteria of Response

The *criteria of response* could not be based solely on the number of pounds lost per month, as it might be in dealing with adults. Weight loss, of course, was one factor in evaluating the response. In addition, height increase, slimness, side reactions, increased physical activity, and mental alertness were also considered.

With the recording of weight, blood pressure, and other data before treatment, each child acted as his own control. Though this was not a double-blind study, it was carefully planned to insure uniform testing procedures. Validity of the results rests on the one anorexic agent used without concurrent therapy of other drugs, special diets, or exercises. The doses of thyroid extract and anterior-pituitary-line were given only to attain normal protein-bound iodine and 17-ketosteroid levels. In these cases, weight losses were consistent *only when patients were under phenmetrazine therapy.*

Results

In the 43 children who adhered to the reducing program, phenmetrazine was found to be an effective anorexiant.

Weight loss. After one to two months of therapy, weight losses up to 20 pounds occurred with a mean loss of 5.7 pounds. This was true of 39 (91 per cent) of the 43 patients (Table 4). In 21 (49 per cent) the loss exceeded 5 pounds. Although one lost no weight and 3 gained less than 4 pounds, these four children grew from one-fourth to one-half inch during this short period.

TABLE 4
CHANGE OF WEIGHT IN 43 PATIENTS AFTER 2 MONTHS OF TREATMENT

Change in Weight (lb.)	Number of Patients
Gained 1 to 5	3
None	1
Lost 1 to 5	18
Lost 6 to 10	15
Lost 11 to 15	4
Lost 16 to 20	2

As treatment progressed through the third and fourth months and weight losses continued, the parents of 15 children were satisfied with the losses obtained and elected to discontinue treatment. Thus only 28 children continued on therapy.

Weight records, obtained again after 5 to 6 months for these 28 patients, showed precisely how body weight changed during the course of treatment. These changes, summarized in Table 5, show a mean weight loss of 4.75 pounds after one to two months. This loss is statistically highly significant†. After 6 months

TABLE 5
PATTERN OF WEIGHT CHANGE AFTER 5 MONTHS

	Mean Weight (lb.)	Mean change (lb.) during interval	(±standard error)
Before treatment	109.84		
After 1 or 2 months	105.09	—3.89	(±0.68)*
After 5 or 6 months	101.20	—3.89	(±0.85)**
Total loss after 5-6 months		—8.64	

the same patients had a mean loss of an additional 3.89 pounds, which is also highly significant†. Thus, these 28 children lost an average of nine pounds during 5 or 6 months of therapy. They also had an average increase in height of one and a half inches during this period. With proper adjustment of height increase to weight loss (figuring 3 to 5 pounds for every inch in height), the actual weight loss suggests an even more significant relationship. Despite the relatively low weight losses which could be recorded, a definite change in body

†t was 7 and P was less than .01 for the first group; for the later period, the t was 4.6, and the P was less than .01.

*Change is highly significant ($t = 7.0$, $P < .01$).

**Change is also highly significant ($t = 4.6$, $P < .01$).

figuration was apparent. Most of the subjects lost the bloated look typical of the obese child, and their clothes became loose on them. Many parents commented that their children were more alert and more active physically, and voluntarily took more part in athletics. Five parents said that teachers had noticed a marked improvement in their children's scholastic achievement.

Rate of weight loss. In the group as a whole, the greatest weight loss was usually attained during the first 3 months of therapy, followed by a gradual slackening off during the next 3 months. The 17 patients under treatment for 7 to 12 months were mainly those with the greatest overweight who wanted to lose a few additional pounds after the 6-month period. In these cases, therapy was discontinued for a month or two and then resumed; weight losses again followed a similar pattern and tapered off after the third month of the second course of therapy.

Blood pressure. Throughout treatment, blood pressure in the initial group of 51 patients showed no substantial variations from normal. The general trend was a slight reduction in both systolic and diastolic pressure similar to that noted in the group of 28 patients (Table 6) who were followed through for the 5 to 6-month period. In this group, an average decrease of 4.5 mm. systolic and 4.7 mm diastolic pressure was recorded, compared with pretreatment control pressures.

TABLE 6
CHANGES IN BLOOD PRESSURE

	Average Blood Pressure	
	Systolic	Diastolic
Before treatment	120.7	79.2
After 5-6 months	116.2	74.5
Difference	-4.5	-4.7

Side effects. The following side effects, usually mild and transient, occurred in 20 (39 per cent) of the 51 children: "nervousness" (17); insomnia (3); epigastric pain (3); tachycardia (1); and dry mouth (2) (Table 7). Medication was withdrawn in only one case. That was a 12-year-old boy who still showed "nervousness" after one month of treatment when the dose had been decreased from 25 to 12.5 milligrams. In the other patients, side effects disappeared when the dose was diminished for a short period and then gradually increased. The three children who experienced insomnia had taken the drug late in the day because they had forgotten their lunchtime dose. When proper dosage time was strictly observed, no insomnia occurred.

TABLE 7
SIDE EFFECTS OF PHENMETRAZINE

Effect	Number of Patients	Incidence (per cent)
"Nervousness"	17	33.3
Insomnia	3	5.9
Tachycardia	1	2.0
Epigastric pain	3	5.9
Dry mouth	2	3.9
Total with side effects	20	39.2
Total requiring discontinuance of drug	1	2.0

Discussion

Phenmetrazine, in the doses used in this study, was an effective appetite depressant. These children could tolerate much higher doses than adults of proportionately greater weight. Though the drug was administered initially according to weight, the direct relation of body weight to dosage could not be generally established, since some of the younger children weighing under 100 pounds well tolerated 25 to 50 milligrams daily. Even on these higher doses, side effects were mild and transient. With meticulous supervision and conscientious adjustment of dosage to individual needs, phenmetrazine produced an excellent anorexiant effect with minimal central nervous stimulation. As has been generally observed,[28] most obese children are usually less active physically (and, at times, mentally) than children of normal weight. The slight stimulating action of the drug appeared to have an overall beneficial effect. No sign of habituation was seen in any of the children treated.

Some observers fear that anorexiants will cause increase in blood pressure. The slight decreases noted in most patients in this study contradict such reports. Phenmetrazine does not significantly raise blood pressure. Weight loss tends to *decrease* blood pressure to some degree.

As weight losses were recorded, it became apparent that it was unnecessary to put children on strictly curtailed diets. They usually rebel against such restrictions by eating secretly or by developing animosities towards parent or physician.

The girls were more cooperative than the boys. The ideal age to start reducing programs would seem to be about 9 years in girls and 11 in boys. In younger children, it may be difficult at times to obtain the fullest degree of cooperation.

A relaxed atmosphere at home with the easing of all tensions, as well as a comfortable rapport with the physician, are of great help in fostering the understanding and cooperation of both child and parent. Their joint efforts are imperative for the success of any reducing regime. During the study, parents were relieved of the burden of preparing special diets, and were pleased with their children's weight loss, increased physical activity and scholastic improvement.

Summary

1. A reducing program for children should not be started without (1) a meticulous physical examination with family and personal history; (2) a careful laboratory work-up to determine any endocrine abnormalities; and (3) complete cooperation of parent and child.

2. Vitamins should be given concurrently.

3. Dietary restrictions at regular mealtimes are unnecessary since greatest weight gains in obese children are caused by excess calories consumed between meals. An appetite depressant is most effective given with lunch so that the maximum effect is exerted during the afternoon.

4. Phenmetrazine, a sympathomimetic amine of the oxazine group, was administered in doses of 12.5 to 50 milligrams daily to 51 children, ages 4 to 16. Dose was initially related to body weight and then adjusted as required. Most subjects received treatment for from 3 to 6 months. Eight children who did not cooperate fully were excluded from the final evaluations.

5. After 1 to 2 months of therapy, weight losses of 1 to 20 pounds, with a mean loss of 5.7 pounds, occurred in 91 per cent of the patients. As weight loss progressed through the 3rd to 4th month, 15 parents felt their children had lost enough weight to discontinue treatment. In the 28 who continued until the sixth month, mean weight loss was 8.64 pounds, which was statistically highly significant. Mean increases of one and a half inches in height during this period suggested an even more significant interpretation of actual weight loss.

6. Phenmetrazine is most effective during the first two months of treatment.

7. Side effects, mainly "nervousness," in 20 children were minimal and transient; and in only one case was it thought advisable to discontinue treatment.

8. A slight mean reduction in blood pressure, commensurate with weight losses, was recorded at the end of therapy.

9. Phenmetrazine in the doses used in this study was an effective anorexiant and well tolerated. No sign of habituation was noted in any case. Both parents and children appreciated the weight losses obtained without the need of dietary restrictions.

An extensive bibliography may be obtained from the author. The listing of 28 citations appears in Dr. Fischman's reprints.

187 Chancellor Avenue

Parliamentary Procedure At a Glance

Send a nickel (no stamps!) and self-addressed stamped envelope to George Schmitt, M.D. and get a compact little sheet on parliamentary procedure that will give you a quick answer to parliamentary procedure. Send Dr. Schmitt a 4¼ by 9½ envelope (that's the usual "long" envelope) with a 5c stamp on it pre-addressed to yourself. Scotch-tape a nickel to a card and ask for his "Parliamentary Procedure Sheet." Use it and you'll never be out of order. Address: G. F. Schmitt, M.D., 30 South East 8th Street, Miami, Florida.

All lateral condylar fractures of the humerus, suggests Dr. Lorello, should be treated by open reduction, unless they are simply linear.

Fracture of the Lateral Humeral Condyle in Children

Robert J. Lorello, M. D./Belleville

Fracture of the lateral condyle of the humerus in children is one of the few traumatic conditions of the osseous system in children requiring open surgery. Complications of imprudent treatment are: non-union at the fracture site, subsequent severe valgus deformity of the elbow, and tardy ulnar nerve palsey.

Authorities on fracture surgery (including Watson-Jones,[5] Blount,[1] and McLaughlin[4]) agree on the necessity for open reduction in the treatment of displaced fractures of the lateral condyle. They also agree that essentially *undisplaced* fractures may be treated closed by manipulative reduction and application of immobilization with the elbow in flexion. The case presented below is one in which an essentially non-displaced fracture treated properly went on to established non-union, and subsequently required open reduction.

A 2-year-old boy fell on his elbow and fractured the lateral condyle of the left humerus. He had no past history of any significant injury or disease. Physical examination was normal except for the left elbow which was swollen and tender on its lateral aspect, with its range of motion markedly restricted. There was no evidence of neurovascular or tendon impairment. Pulses at the wrist were easily palpable. X-rays at the hospital revealed an essentially undisplaced fracture of the lateral condyle of the left humerus.

On the day of the injury, the child had a closed reduction and application of plaster. The arm was placed in full supination and 90 degrees of flexion. Post-operative films demonstrated no change in position, and the patient was discharged uneventfully 48 hours after the accident. The cast was removed six weeks later. At that time, x-rays demonstrated maintenance of position but possibly early non-union. X-rays of the left elbow three months later demonstrated established non-union. A few days later, he was re-admitted to Clara Maass Memorial Hospital, and open reduction was done the next day. At that time, we noted non-union with a barrier of fibrous tissue interposed between the fragments. This was removed, osseous contact established, and the lateral condyle fragment transfixed to the distal humeral shaft with two fine Kirschner wires. Final x-rays taken three months later demonstrated a healed fracture in good position.

Clinically, range of motion of the elbow was normal, there was no valgus or varus deformity, and no neurovascular impairment. Examination one year later revealed a normal elbow, except for slightly increased prominence of the lateral epicondyle.

This is a case of non-union of an essentially non-displaced fracture of the lateral condyle of the humerus. It is my opinion that all lateral condylar fractures of the humerus must be treated by open reduction unless they are simply linear. In speculation into the reason for non-union in cases like this, I suggest the role of the more rapid absorption of the fracture hematoma by the joint lining. This is to be especially considered in view of the intra-capsular position of the fracture. Again, in view of its intra-capsular position, the role of synovial fluid, acting as a deterrent to union, is open to investigation.

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50 Newark Avenue

The peripheral vessels represent one of the last domains to yield to the surgeon's knife.

Surgical Implications of Peripheral Arteriosclerosis*

William E. Philip, M.D.†/Morristown

The last decade has seen the fledgling art of arterial surgery develope from infancy to what, at the time of these observations, appears at least to be young maturity. Such growth has been dramatic and perhaps most evidently manifest in the approach to the arteriosclerotic abdominal aneurysm which at first was assiduously avoided, later warily wired, then surreptitiously surrounded; and finally, with the advent of prosthetics, was vanquished for the most part. Even today, however, all who come to grips with this lesion have experienced moments of deep introspection. There is, nevertheless, greater unanimity of opinion concerning the management of this aneurysm, whatever its location in the lower vascular tree, than is found in most other lesions. Resection of the involved segment with prosthetic replacement has been satisfactory in most cases. However, the distal run-off will directly affect the results of the resection. In the presence of good femoral pulses, it is usually possible to utilize the iliac vessels or carry the graft into the thigh for anastomosis with the femoral vessels, preferably the common, because of its larger size. In the absence of such pulses (and the failure to fill on aortography, which we do in most cases in order to delineate the extent of concomitant renal artery involvement), it may be well to explore the femoral vessels before excision of the aneurysm if the iliac vessels present no suitable area for junction.

Review of the last 20 cases of aortic abdominal aneurysms resected during the past 4 years discloses two deaths for a mortality of 10 per cent. One of these was a 52 year old hypertensive who died of anastomatic hemorrhage on the third post-operative day with a rising blood urea nitrogen level. This was in the face of high doses of heparin given because of bilateral ischemia of the lower extremities despite good femoral pulses. Autopsy disclosed severe bilateral renal artery disease and arterial disease in the femoral and popliteal vessels. Cognizance of the extent of the renal artery disease and disease of the distal extremities may well have dissuaded us from this salvage attempt. The second death occurred 6 hours postoperatively in a 69-year-old hypertensive patient who resumed spontaneous respirations slowly following the use of a muscle relaxant during surgery. Post-mortem failed to disclose an anatomic cause of death which was, therefore, assumed to be recurrent respiratory depression. Of the surviving group, the prothesis (a woven bifurcated Teflon graft) has functioned well without late failures. The longest period of observation in the series has been four years.

In contrast to the singleness of the technic with lower aortic aneurysms, obliterative disease in this area has been approached in a myriad of ways. Our approach has been primarily pragmatic, being governed for the most part by the nature of the disease as found at

*Read May 18, 1964 at the Annual Meeting of The Medical Society of New Jersey in Atlantic City.

†Cases reported herein were operated on the author's services at Dover General Hospital, St. Clare's Hospital, Denville, N. J., Morristown Memorial Hospital; and All Souls Hospital, Morristown, N. J.

exploration. Relatively short areas of disease of the distal aorta and proximal iliacs, in the younger patients particularly (if without extensive calcification), usually separate satisfactorily, leaving a good sized lumen and firm wall. In favorable cases, endarterectomy is carried proximally to the renal vessels. With the more extensive disease, however, a by-pass graft has usually been favored, particularly if a suitable segment for the end to side anastomosis can be found immediately beneath the renal vessels on the anterior aortic surface. Presented with extensive disease high in the abdominal aorta, resection usually has been carried out with a more proximal endarterectomy during intermittent unclamping of the aorta. In such circumstances, this process is required, in fact, for any reconstructive attempt since the absence of a good proximal head of pressure will doom the procedure. Patching has rarely been necessary for closure following endarterectomy of the larger vessels.

We did not have a single failure among the 8 endarterectomies completed over the past three years. Restoration of function of the lower extremities has been satisfactory and, in most cases, pedal pulses were restored in this selected group.

Evaluation of the aorto-femoral by-pass procedures (nine cases in all) operated over the past 30 months has included a more severely diseased group, older and with a higher incidence of hypertension and diabetes. Three of these were failures. In two, progression of already existing gangrene could not be prevented, and below knee amputation was required. In the third, a 67-year-old man with severe diabetes presenting with early gangrene of both feet, aorto-bi-femoral grafting was an immediate operative failure. Bilateral amputation was eventually required. The patient died one week later in congestive failure. Hence, failures 33 per cent and mortality 11 per cent were, as expected, considerably higher in this salvage group. Of the remaining group, three had satisfactory restoration of function and three avoided impending tissue loss of the distal lower extremities.

All of the foregoing had previous percutaneous translumbar aortography for evaluation of the location and extent of disease. Additionally, this method of investigation has been used with greater frequency in aneurysmal lesions to locate associated renal artery disease which may require concomitant surgery.

During the past three years, 60 aortograms have been completed by the percutaneous route under local anesthesia, employing a #16 seven inch needle and injecting manually 20 cubic centimeters of 90 per cent or 75 per cent diatrizoate (Hypaque®) well above the celiac axis. Multiple injections are used if necessary.

The needle is introduced several centimeters below the last rib on the left and well away from the mid line, usually about 10 centimeters. Introduction medially and posteriorly produces contact with the body of the vertebra. Following this, the needle is withdrawn and introduced more anteriorly and more superiorly towards the tip of the scapula. Usually, aortic pulsations are easily detected by the probing tip and entry to the lumen denoted by the sudden loss of resistance. With removal of the stylet, a good pulsatile flow is evident and a small test dose of the opaque media given. This is followed by rapid injection of the full 20 cubic centimeters. Rapidity of injection is the most important factor in satisfactory visualization. Double or triple the amount of dye given more slowly into this rapidly moving stream will not yield satisfactory contrast. Comparative evaluation of renal function may also be obtained if additional exposures at two, three, four, and five minute intervals are processed. Information is thus available that cannot be gleaned from the usual intravenous pyelograms and demonstrates, ordinarily, satisfactory nephrograms.

Only one complication has occurred in this group—a hemorrhage from the site of puncture in a severely hypertensive female sufficient to be detected on chest roentgenography, but requiring no therapy. The simplicity, rapidity, and informative nature of this procedure has continued to recommend its use.

Below the renal vessels, the next anatomic line significantly influencing distal vascular surgery is the inguinal ligament. Ischemia of the lower extremities in the presence of good femoral pulses requires, ultimately, femoral arteriography for a decision as to the feasibility of reconstructive surgery. In most cases of threatened or beginning tissue loss or severe persistent pain, femoral arteriography is indicated to determine the presence of a suitable popliteal vessel for anastomosis.

Injection of 20 cc. of 35 per cent diatrizoate (Hypaque®) solution may be made slowly into the femoral artery and the popliteal space included in the exposure made at the completion of the injection. When the popliteal pulse is unobtainable, the block is usually demonstrated in the distal superficial

femoral artery; and the popliteal, if patent, fills *via* collaterials. Most of these patients can tolerate arterial surgery as well as amputation, and hence we customarily favor an attempt at salvage. Without a patent popliteal, lumbar sympathectomy is considered, although results here are and have been highly variable and in all probability will remain so until a satisfactory method of evaluating the vasodilatory potential of the distal vessels becomes generally available.

Surgical intervention for claudication alone requires evaluation on the basis of age, occupation, temperament, and over-all physical condition. Most frequently it has been undertaken to permit return to gainful occupation, but occasionally after adequate explanation, patients have been accepted who could not adjust to physical restrictions.

Because of the extensiveness of the arteriosclerotic process encountered in the vast majority of cases, femoral popliteal by-pass has been elected in most instances of superficial femoral block. The long by-pass from common femoral to mid or distal popliteal has required the use of a synthetic prothesis, usually of the woven crimped Teflon®. This has been placed through an anterior incision initially, the graft clamped after the proximal anastomosis has been completed and is then tunneled along the course of the superficial femoral artery to the upper popliteal space. The patient is then turned from supine to prone position, a separate incision made in the popliteal space allowing the distal anastomosis to be completed at the most propitious location in the popliteal space. Removal of the proximal clamp on the graft close to its origin permits the by-pass to begin functioning, and this is observed while the popliteal wound is closed.

Utilizing this technic, 22 by-passes have been completed with a minimum follow-up period of one year and a maximum of five years. There were three failures, two immediate and one at 2 months—a failure rate of 14 per cent. These failures resulted in persistence or return of disability, but no tissue loss. Following successful grafting, gangrenous tissue separates and is replaced by viable granulations which readily accept grafts, the lower leg and foot become warmer, pedal pulses often return, and claudication either clears completely or is markedly improved. Pain in the foot and toes is lessened, but may persist for many months retaining many of the characteristics of an ischemic neuritis.

Among the 19 successes, 7 patients avoided amputation while the remainder were relieved of pain or restored to full function.

Morbidity in the group consisted of 5 patients who gave evidence of deep thrombophlebitis, such as extremity pain, swelling, and edema of the lower leg and foot on the operated side. Of these five patients, two evidenced clinical infarction. Care was taken to minimize femoral vein trauma, and in most instances the vein was undisturbed except for those areas in which the artery was cleared for anastomosis. Because of this incidence of phlebitis, oral anticoagulants have been started on the fourth postoperative day and continued for a minimum of several weeks after surgery.

Alternative methods of improving distal blood flow have included extensive endarterectomy with and without vein patching and utilization of saphenous vein for femoral popliteal by-pass. Success with extensive endarterectomy has been limited at this level, and extensive vein patching utilizing a 10 to 15 centimeter patch is time consuming. Additionally, such procedures disturb existing collaterals, thereby increasing the hazard of the operation. Vein by-pass offers several advantages insofar as the vein stands up well at this level without aneurysmal dilatation and there is no introduction of a foreign body. Late failures are less, since a neo-intima is not required and kinking at the flexion of the knee is less of a problem. It does, however, increase the operating time and limits the extent of the by-pass to that of the utilizable segment of saphenous vein that can be recovered. Such a limitation may be of considerable importance, particularly when the demonstrated segment of disease extends well down into the popliteal artery.

Little success has thus far been achieved utilizing vessels below the popliteal. Satisfactory surgical approaches, possibly employing stapling devices or micro technics, may alter this situation so that a direct approach to the vessels below the knee will no longer be inferior to the surgeon.

29 De Hart Street

STATE ACTIVITIES

Trustees' Minutes

October 18, 1964

A regular meeting of the Board of Trustees was held on October 18, 1964, at the Executive Offices. For the information of the membership, detailed minutes are on file with the secretary of each county society. A summary of the significant actions follows:

MAA Program . . . Assigned to the Committee on the Chronically Ill and the Aging the responsibility for studying and making recommendations for the improvement of the Medical Assistance to the Aging Program in New Jersey.

JOURNAL *Advertising* . . . Received the following communication from Legal Counsel concerning JOURNAL advertising income and the Internal Revenue Service:

A member of the Board of Trustees recently inquired about the decision of Internal Revenue Service affecting JOURNAL advertising income. Investigation made after such inquiry reveals no particular ruling but the following which should be of interest to the Board of Trustees.

Internal Revenue Service is drafting new regulations which would classify the advertising revenue of tax-exempt trade groups as "unrelated business income." Such income would be subject to a fifty percent tax The government today, even without this proposed new regulation, has already moved to tax some income of tax-exempt organizations, namely, income from commercial exhibits at conventions.

The recent about face by Internal Revenue Service with regard to tax-free organizations was provoked by group protestation against "government-subsidized" competition. A business-paper publishing association, for instance, criticizes the AMA Journal for "competing boldly and strenuously for advertising while operating from a cosy tax sanctuary." This type of criticism has made Internal Revenue Service, heretofore preoccupied with other federal income sources, redirect its attention to the interpretation and enforcement of a 1950 law governing "unrelated business income." A constantly growing number of tax-free organizations and publications with advertising apparently has given objecting groups some fuel for their objections.

The critical issue involved is whether the purpose of the advertising is to raise money or to serve objectives which are the basis for an association's tax exemption. If ads are sold to reduce dues, federal officials believe that an association should be considered as conducting a business. The AMA, which will consider an official protest only after adoption of the regulations, maintains, of course, that the advertising in its publications goes hand-in-glove with its education mission by apprising physicians of new medical devices and medicines. Other effective arguments can readily be made.

Once drafted, a regulation will go to the Treasury Department for approval, after which comments at open hearings will be invited prior to issuance of a final order. Federal Court action to overturn any unfavorable Internal Revenue Service ruling might also be expected.

Cancer Detection Examinations . . . Recommended to the New Jersey Division of the American Cancer Society that an annual poll of the 1,300 examining physicians be taken to determine how many people have had cancer detection examinations, and if possible, the number of cancer cases found.

Smoking and Lung Cancer . . . Agreed—in furtherance of an educational program for junior and senior high school students either to stop smoking or not to start—to invite former Governor Meyner to the next meeing of the Committee on Cancer Control, to solicit his suggestions in promoting a workable educational program.

Drug Addiction . . . Authorized the appointment of a subcommittee (of the Council on Public Health) to study the distribution of disposable syringes and needles and to develop, if possible, a more satisfactory solution.

Annual Meeting . . . Received the report of the Annual Meeting Committee reaffirming its opinion that the annual meeting should continue to be held in the spring; that, for the first time in 1965, seating in the House of Delegates should be by county, by district; agreed that, for the 1965 Annual Meeting, the MSP discussion be listed "to follow the close of the House Session" instead of at a specific time.

Seton Hall Medical School . . . Directed that the following statement be released to newspapers, with copies to the Governor, legislators, component societies:

1. In order to emphasize its support of the report of the Governor's Seton Hall Fact-Finding Committee, The Medical Society of New Jersey emphatically declares that it specifically advocates an independent, unhampered Board of Trustees for the proposed reconstituted New Jersey State College of Medicine and Dentistry. Further it strongly opposes encumbering that Board of Trustees in any way, by any restrictive

in futuro provisions other than those explicit statutes or in the regulations of the Department of Education of the State of New Jersey.

2. In addition to its previous affirmation of the principle that the primary purpose of any existing or proposed medical school in this state is the production of practicing physicians rather than research graduates, The Medical Society of New Jersey expresses itself in favor of strong support by such schools of programs of teaching in the community hospitals. Such teaching should be directed not only to intern and residency training but also to the ongoing education of physicians in practice.

3. Without in any way depreciating research or belittling its importance, The Medical Society of New Jersey expresses its conviction that medical schools now being established or reorganized should adhere to a policy of "first things first." Thus, until satisfactory programs of student and intern training have been demonstrated to have been developed and to be satisfactorily operating, the medical schools in this state should not allow research activities or interests to divert the attention of the members of their staffs, or permit graduate non-M.D. programs to detract from their zealous pursuit of their primary purpose to produce practicing physicians. When it appears that such practitioner training objectives have been achieved, and M.A. and Ph.D. training programs can be safely added to the primary training objectives of the schools, these graduate programs should be conducted within the framework of regular graduate instruction of regular, duly constituted graduate faculties which include basic science departments, and in accordance with specific programs previously submitted to, and approved by, the Commissioner of Education of the State of New Jersey.

County Presidents . . . Arranged for a morning meeting with the presidents of component societies to "encourage free and open discussions for improved mutual understanding of problems of the State Society as well as of the component societies;" met with component society presidents in the afternoon and received the following report:

a) *Sponsors of Resolutions* . . . The presidents were in agreement with the suggestion that any county or delegate that sponsors a resolution should be represented before the reference committee to which the resolution is referred by some one well-informed concerning the resolution and able to speak in its behalf.

b) *Amendment of Reference Committee Reports* . . . The presidents were in agreement—provided it would not put an end to oral discussion from the floor of the House—that it would be much more satisfactory if amendments to reference committee reports were submitted to the office for mimeographing and distribution to the House at the time at which reference committee reports are being considered.

c) *House of Delegates Attendance* . . . The presidents spent a great deal of time discussing attendance at House sessions and the methods for getting delegates to attend and were in agreement that delegates' attendance has been fairly good. County presidents agreed that they do have a problem disciplining delegates who neither attend the sessions nor arrange for alternates in their place. The presidents favored the interval of one day between the second and third sessions, and agreed that the schedule should be continued.

d) *Emergency Medical Coverage* . . . The presidents agreed that this problem must be solved by component societies, since a statewide system would not be practical or workable.

e) *Miscellaneous* . . . The presidents also discussed the number of visits and drug prescriptions for welfare patients and the two year time limit for associate membership in conjunction with those associate members in residencies.

Urged presidents to encourage medical staff bylaws of their local hospitals to include the requirement recommended by the Society: "An applicant for a staff position must be a member of that professional society or association in which his doctoral degree entitles him to hold membership." This requirement would be in the best interest of protection of the public since qualifications of applicants for staff positions will have been fully investigated by the professional societies and such members would be subject to, and controlled by, the exactions of codes of ethical conduct and standards of professional deportment in addition to those of civil law.

Help to Foreign Physicians

The counselling and placement of refugee physicians in the United States (formerly done by the National Committee for the Resettlement of Foreign Physicians) is now being done by the American Council for Emigres in the Professions, Inc., 345 East 46th Street, New York City 10017.

The American Council for Emigres in the Professions, Inc. is a non-profit, non-sectarian service organization devoted to the talent conservation of refugee professionals. Since 1945, it has helped thousands of professionals to find employment in America and to make full use of their abilities—especially where there are shortages of trained personnel in such areas as the sciences, education, industry, and research.

To accommodate the needs of emigrating physicians, a Physicians Division has been organized within ACEP to continue the work of the National Committee. Since its founding in 1939, the National Committee (NCRFP) has enabled almost 23.000 refugee-doctors to become part of the medical community of our country. As an indication of the variety of positions it has filled, the organization last year placed foreign physicians in approved internships and residencies, staff posts, research fellowships, private practices, and instructorships. Other doctors were placed as admitting physicians, laboratory technicians, and child camp physicians. Plans to broaden the scope of this work are presently underway by the new ACEP Physicians Division.

For further information, inquiries should be addressed to:

Physicians Division of the Council for
Emigras in the Professions,
345 East 46th Street
New York, New York 10017

Rutgers Medical School

This is the first of a series of reports on Rutgers Medical School which will appear periodically in your JOURNAL.

The aims and purposes which guide the development of Rutgers Medical School form the text of this communication.

1. It is our intention to create at New Brunswick the finest medical school, judged by contemporary standards, that we are capable of creating. We will make no unnecessary compromises with excellence.

2. For this, and indeed for all other proper medical schools, the primary *raison d'être* is the preparation of physicians. Approximately 95 per cent of all medical school graduates enter one or another form of medical practice, and we fully expect that our graduates will conform to this pattern.

3. The accrual of medical information is rapid and exponential. The first two years of basic medical education must provide a solid foundation upon which clinical skills can be built for many ensuing years. This imposes upon the teacher and the school the need for a continuous quest for improved curricula and better teaching methods.

4. Even as a two-year or basic medical science school, we will make more liberal use of clinical material in our instruction than has been customary. Many of the important principles of anatomy, physiology, biochemistry, and so on, are best exemplified in human material. The patient is the most effective memonic for the medical student.

5. In addition to the traditional six basic science subjects, two clinical departments were included from the very beginnings of planning. The importance of these departments in our thinking is revealed by the fact that among the first three departments to be staffed are the clinical departments of medicine and psychiatry.

6. We shall lean heavily upon regional community and Veterans Administration hospitals for the requisite clinical experiences of our students. Negotiations between Rutgers Medical School and regional hospitals over the past two years will soon, we expect, lead to enduring and reciprocally profitable affiliation agreements.

7. In light of the experience of many other medical schools, we propose to remain a two-year school unless and until funds for the construction of a university teaching hospital become available to us. To operate an excellent two-year school is an altogether appropriate goal. Expansion of the program to encompass all four years of medical education should be undertaken only if the quality of instruction is not compromised thereby.

8. We shall continue to study and be responsive to the needs, in New Jersey, for continuing education of physicians. Insofar as it lies within our capacities, we expect to participate in such programs.

DeWitt Stetten, Jr., M.D., Ph.D.
Dean

BOOK REVIEWS

Your Weight and How to Control It. Edited by Morris Fishbein, M.D. New York, 1963, Doubleday & Company. Pp. 206. ($3.95)

On the inside cover of the jacket of this book the first paragraph promises: "All the latest medical information on how to gain weight, how to lose weight, and how to maintain correct weight is thoroughly covered in this new revised edition of *Your Weight and How to Control It.*"

This book could have been written, with very few exceptions, in 1930. Nothing new has been added to what has already been written before in many books, journals, and the lay press.

The twelve contributing writers are well known authorities and what they say makes good reading. However, no one who reads this book will get anything he can use to gain weight, lose weight, or control weight.

Dr. Morris Fishbein's name on the cover is somewhat misleading. With the exception of one small chapter, he has nothing to do with the subject matter between the covers of this book.

S. William Kalb, M.D.

Gastroenterology. By Henry L. Bockus, M.D. Second Edition, Volume 1. Philadelphia, 1963, Saunders. Pp. 958. Illustrated. ($25.00)

Thirty-one experts in various fields of gastroenterology have joined Dr. Bockus in completely rewriting this volume (first issued in 1943) on examination of patient, the esophagus, and stomach. It covers the advances made during the past twenty years.

Those familiar with the first edition will welcome new chapters on oral manifestations of internal diseases and on tests in the study of esophageal function and disease.

The chapter on "Factors Influencing Prognosis of Peptic Ulcer" is an extremely useful one to refer to frequently when dealing with a complication requiring a quick decision in management.

Dr. Bockus reaffirms his preference for stomach rest and hourly feedings in the management of uncomplicated duodenal ulcer. Numerous and varied diet lists are included.

The section on "Hematemesis and Melena" lists (in addition to the intrinsic causes) twelve due to blood diseases, four due to disease of blood vessels, and six due to systemic disease.

The philosophy of approach to treatment of gastro-intestinal bleeding is more conservative than other recent writings but far more radical than in the first edition. Cooling and freezing are considered still in the experimental stage.

In this volume, history, symptomatology, physical examination, and routine laboratory procedures remain the backbone of the approach to the patient's problem. Radiology, endoscopy, special laboratory studies, and exfoliative cytology have been given full recognition as additionally valuable.

The authors have succeeded in the task "To combine science and art in the work-up of the patient and treatment of his disease"—set forth in the preface.

Isaac Gelber, M.D.†

An Introduction to the Science of Human Behavior. By J. I. Nurnberger, M.D.; C. B. Ferster, Ph.D.; and J. P. Brady, M.D. New York, 1963, Appleton-Century-Crofts. Pp. 379.

The clinician, say the authors in their introduction, is more preoccupied with why a person is in distress than with what the difficulty means to the patient. This book is a bold, but not pretentious, effort to give the medical student a picture of the complex substrate of human behavior—the anatomic, genetic, psychodynamic, biochemical, physiologic, and sociologic strands that, woven together, make up *homo sapiens.* Almost half the text is devoted to a "Science of Behavior" monograph by Dr. Ferster. This disproportion seems, to this reviewer, a serious imbalance. The material in this part is of least applicability to the young clinician, and the student's understanding of it is seriously impaired by the author's fascination with technical "behavior science" terms. These chapters are honeycombed with phrases like intermittent reinforcement, operant repertoire, temperal

†Deceased July, 1964.

summation, differential reinforcement, and the like—phrases quite foreign to medical students. Even the parts written by the two physicians sometimes become so involved with the trees that the authors fail to see the forest. Consider such topics as the sedoheptulose shunt, the Krebs tricarboxylic acid cycle, and the effects of a lysine-free medium on the growth cycle of *Escherichia Coli.* It seems unfortunate that these esoteric matters should take up so much of the text.

In spite of this, however, the book serves to remind the reader of the complexity of behavior and the need for a well-rounded, bias-free approach. Probably the freshman medical student (the avowed target of the book) will use this as a display case and select what appeals to him. Abraham Leff, M.D.

Will Somebody Call the Coroner? By Willis P. Butler, M.D. New York, 1963, Vantage Press. Pp. 98. ($2.95).

Dr. Butler was born in 1888, and for 49 years was coroner of the Louisiana parish where Shreveport is situated. He would give talks before many civic groups, and someone suggested that he ought to write a book. He yielded to the suggestion. The book contains about a dozen incidents. The first is a story of how a corpse was misidentified. They exhumed him later. The next one tells us that Dr. Willis casually left a loaded Colt .45 on his desk while he was talking to a narcotic addict apparently on the edge of withdrawal. The addict took the gun and threatened the doctor. One of Dr. Butler's more interesting ideas is that hallucinations are functional and most of them are cured; while delusions are organic and usually persist throughout life. The last case tells how Dr. Butler protected a man accused of rape against a lynch mob composed, he says, of his (the doctor's) "friends, fellow townsmen who ordinarily were law abiding, decent citizens". The culprit, we are told, "was taken through regular channels and legally executed."

In the foreword, Dr. Butler explains that one of his motives in writing the book is "a deep need to seek out the humor in situations which had their difficult, disagreeable, and dangerous sides". Henry A. Davidson, M.D.

Medical Laboratory Technology. By Matthew J. Lynch, et al. Philadelphia, 1963, Saunders. Pp. 735. Illustrated. ($12)

This outstanding volume has impressed your reviewer.

It is conveniently divided into four sections. The basic theory and physiologic mechanisms are clearly set forth for review by the technician performing the test or for information of the physician seeking precise guidance and interpretation. Nothing is left to conjecture from the preparation of the patient to the proper collection of specimens for testing to evaluating results. The advantages and disadvantages of each procedure are given and the most profitable test is indicated. Superfluous material is excluded, and all essential details are included.

Gross and microscopic material are well illustrated. The index is complete, and each chapter supplies references for further investigation and sources of material are supplied.

This book is a *must* for the technician or technician-trainee and invaluable to the treating doctor as a source of information or review.

D. C. Sheehan, M.D.

New and Nonofficial Drugs—1963. Council on Drugs, AMA. Lippincott, 1963, Philadelphia. Pp. 879. ($4.00)

New and Nonofficial Drugs—1963 is a yearly compilation of the information on drugs, including therapeutic prophylactic and diagnostic status. Monographs are limited to individual drugs generally available in the United States that have not been included in the *National Formulary* or the *Pharmacopeia* or *New and Nonofficial Drugs* (NND) for a prior cumulative period of 20 years.

Monographs, arranged alphabetically according to their nonproprietary titles, are grouped according to pharmacologic action or clinical use. The organizational names and addresses of commercial sources of drugs are listed in a separate appendix.

In evaluating drugs the Council considers clinical and laboratory evidence (published or unpublished) submitted by manufacturers and such other reports as may be available. The Council also gets opinions and advice from

consultants. The Council does not conduct tests or experiments.

A copy of the NND belongs in every physician's office along with such other aids as the *Physician's Desk Reference* or the *Modern Drug Encyclopedia.* Drugs are such an important part of every physician's armamentarium that it behooves every one of us to acquaint ourselves with complete information on each preparation we use. Harold S. Feldman, M.D.

Clinical Metabolism and Body Water and Electrolytes. By John M. Bland, M.D. Philadelphia, 1963, W. B. Saunders. Pp. 623. Illustrated. ($16.50)

This new book has been the effort of twenty-one contributors, biochemists, physicists, and physicians. Medicine is now a biological science. Water is the basis of life. This book is well written and will be an asset to all medical men interested in this field of medicine. Surgeons, internists, and general practitioners will find this book something new in aiding them in their own field. The text is well written and easily understood by those who have had a working knowledge of electrolytes and water metabolism. I recommend this volume to all physicians who seek further knowledge in this field.

Wolf Lurie, M.D.

Clinical Examinations in Neurology. By the staff of the Mayo Clinic. Philadelphia, 1963, Saunders. Ed. 2. Pp. 396. With 7 tables and 75 figures. ($8.50)

Neurology ought to be the most logical of specialties. Signs and symptoms follow a specific pattern closely related to the geometry of the brain and cord. However, examinations to be meaningful must be conducted systematically. This Mayo Foundation manual is a handy guide to conscientious neurologic study. There are chapters on how to take a history, how to test reflexes, and how to examine infants, how to test the cranial nerves, how to survey a patient for aphasia, how to measure motor function, how to determine areas of sensory defect, and (somewhat sketchily) how to appraise mental function. In a pocket in the back is a set of neurologic record forms. You won't miss anything if you follow these. An aphasia test form is bound into the text and takes the voodoo out of this field. There are chapters on neuro-ophthalmology, electro-myography, neuroradiology, electroencephalography, spinal fluid study, and pharmacologic aids in diagnosis.

The first edition of this manual was released in 1956. The two chief changes in the past seven years have been expansion of material on examination of infants and a new chapter on roentgenographic technics, including angiography.

As one might expect in any volume from such a source, this is an authoritative, expert book that will improve any doctor's neurologic skills. Jose Vilanova, M.D.

The Risk Takers. By Hugh McLeave. New York, 1963, Holt, Rinehart and Winston. Pp. 208. Illustrated. ($4.50)

No, this is not a book on investments. It is a journalist's account of heart surgery. In the early days, everyone involved was taking a deliberate risk—the surgeon, the patient, the anesthesiologist. But the risks paid off, and the last of the surgically inaccessible organs has become vulnerable to the scalpel. The book tells its story through dramatic anecdotes involving specific patients. It covers pace-makers, cardiac catheterization, hypothermia, and all varieties of cardiac surgery. Mr. McLeave is remarkably skillful in describing anatomic, physiologic, and surgical facts in clear, accurate, and vivid fashion comprehensible to the sophisticated layman. The book is a testament to progress in medicine and surgery, a source of hope to cardiac patients and their families and a record of human activity of which all of us can be proud.

Victor Huberman, M.D.

The Functional Pathology of Disease. Edited by Arthur Grollman, M.D. with contributions by 26 other authorities. New York, 1963, McGraw-Hill. Ed. 2. Pp. 979. Illustrated. ($15)

In 1957, under the title *Clinical Physiology,* Dr. Grollman edited the original edition of this work. In the intervening six years there has been enough progress in physiology to justify a modernization of the text and of the citations.

New material has been added on neurophysiology, auto-immune disease, diabetes, and arthrology.

This book correlates clinical medicine with the basic physiology, biochemistry, and pharmacology that underlies it. We have all come to realize that medical practice is an art involving a kind of intuition, not to say a mystique, that defies verbal description within the covers of a book. But medicine is also a science, and it is good to have a solid text like this to remind us of that. If the reader thinks that sometimes the total patient is lost with so much attention paid to lipid metabolism, intracellular fluid, and the posterior lobe of the pituitary, he must be reminded that our art is useless unless erected on a scientific platform. Most of the chapters are written in a didactic, no-nonsense style which makes the volume essentially a work of reference rather than a reader. The book's usefulness is enhanced by a usable index and a rich reservoir of references at the end of each chapter.

Ulysses M. Frank, M.D.

Textbook of Medicine. Edited by Paul B. Beeson, M.D. and Walsh McDermott, M.D. 11th Edition. Philadelphia, 1963, Saunders. Pp. 1835. ($19.50 single volume; $23.50 two-volume set)

To attempt to offer a complete review of such a magnificent text would be foolish. This new addition of a respected and authoritative medical text covers over 800 disease entities in 2000 pages. The presentations are clear, concise, and up-to-date. This text represents the contributions of 173 authors. It should be within reach of the intern as well as the internist.

Those having special interest might take issue with the space and time given to various subjects. The reviewer accepts these possible discrepancies because the treatment of each subject is so scholarly.

The book is so big that it is frightening at first glance. However, the complete table of contents immediately simplifies use of the text. Above all, however, the complete and meticulously prepared index makes use of this book both easy and pleasurable.

David Eckstein, M.D.

Moving Into Manhood. By W. W. Bauer, M.D. New York, 1963, Doubleday & Company, Inc. Pp. 107. ($2.95)

Doctor Bauer, a prolific author and former editor of *Today's Health* (nee "Hygeia"), has joined the myriad contributors to the sexual education of the young. "Moving Into Manhood" is inexpensive, not too bulky, and encompasses much information in a succinct manner. It cannot be given over to the growing boy without qualification. If you recommend it, ask the parents to read it first. I can envisage many not liking the ultrafrank, rather clinical approach to sexual physiology extending even to a description of copulative technic. Nor can certain portions be intelligible to a youngster without schematic drawings. To define cell structure and the like without accompanying diagrams is incomprehensible. The admonitions concerning alcohol, tobacco, and drugs are sanely presented and are distinctly worthwhile.

On the whole an excellent presentation, but this reviewer prefers Doctor George Corner's *Attaining Manhood.* George Heller, M.D.

Endocrine and Metabolic Aspects of Gynecology. By Joseph Rogers, M.D. Philadelphia, 1963, W. B. Saunders Company. Pp. 189. Illustrated. ($8.00)

The author says that his book is intended as a *short* review of this field; and in this, he succeeds. However, the field of gynecologic endocrinology is expanding so rapidly that it no longer can be adequately handled in this manner. The metabolic aspects of the functioning woman are poorly understood at best. This text barely scratches the surface.

The best section is one on chromosomal aberrations and gonadal defects, which gives a reasonably presented, up-to-date capsulation of recent information. But generally, the presentation is a biased one throughout. The advice on therapy is minimal. The bibliographies are extensive but not selective. Many subjects are treated so briefly that the conclusions are confusing.

As a review reference in an otherwise adequate endocrinologic library, it is interesting; as a basic source of information, it is inadequate. J. B. Skelton, M.D.

Synopsis of Pediatrics. By James G. Hughes, M.D. St. Louis, 1963, Mosby. Pp. 1031. ($9.85)

When a thousand page book can be called a synopsis, an immense body of knowledge must have been accumulated through the years in pediatrics.

I applaud the various contributors who have pared down existing facts and theories to valuable, proven essentials. Twenty-one pediatricians have made monographic contributions, each on a different subject. Academic or research material which may not have direct clinical application has been excluded. Information has been extracted from larger and well-known treatises which could be referred to for more details and illustrated information. This book is not a "read and run" tome. It covers the subjects clearly and concisely but thoroughly. The discussions on endocrinology and pediatric surgery are particularly valuable. An example of the attempt at clarity is that the chapter headed "Disorders of Coagulation" is separated from that called "Pediatric Hematology."

I was amazed at the clarity which the author was able to bring to "Mesenchymal Diseases in Childhood." Each writer rounds out his subject with an excellent description of the latest therapy employed in each disease category. This book is a helpful delight to the busy pediatrician. Ralph N. Shapiro, M.D.

Books Received

Smoking and Your Life. Alton Ochsner, M.D. New York, 1964, Julian Messner. Pp. 144. ($3.00). A revised edition of Dr. Ochsner's hard-hitting critique of the folly of smoking—a 1964 version of his original 1954 book.

The Psychedelic Experience. Timothy Leary, Ph.D.; Ralph Metzner, Ph.D. and Richard Alpert, Ph.D. New Hyde Park, N. Y., 1964 University Books. Pp. 159. ($5). A description of a journey "to new realms of consciousness" set off when LSD or other psychedelic drugs free the central nervous system of its usual structured pattern.

The History of Prostitution. Vern L. Bullough, Ph.D.. New Hyde Park, N. Y., 1964 University Books. Pp. 304. ($7.50). A history of the old profession from the chimpanzees who offer sexual services in return for food down (or up) to modern practitioners who involve themselves with British cabinet ministers. Not illustrated.

1001 Places to Live When You Retire. H. Heusinkveld and N. Musson. Chicago, 1964, The Dartnell Corporation. ($5.95). Ready reference listing to all kinds of facilities for retired people.

The Visual Fields. By David O. Harrington, M.D. St. Louis, 1964, Mosby. Ed. 2. Pp. 386 with 327 pictures. ($16) A second edition of a comprehensive and practical text and atlas of perimetry.

Clinical Neurology. By Frank A. Elliott, M.D. Philadelphia, 1964, Saunders. Pp. 688. Price not stated. A thoroughly up-to-date, brand new text, emphasizing the clinical methodology of the field.

Surgery of the Breast. By Louis H. Jorstad, M.D. St. Louis, 1964, Mosby. Pp. 220 with 70 illustrations. ($15) A detailed manual of indications, technics, prognosis and ancillary treatment methods.

The Community Mental Health Center. American Psychiatric Association, 1964, Washington, D. C. Pp. 219. ($3). Paperback. An examination of typical mental health centers as possible models for the future.

Milestones in Nutrition. By Samuel A. Goldblith, S.M., Ph. D. and Maynard A. Joslyn, M.S., Ph.D. Westport, Connecticut, 1964, The Avi Publishing Co., Inc. Pp. 797. ($14.25) A collection of original and often out-of-print early papers in the history of nutrition.

Proteins and Their Reactions. By H. W. Schultz, Ph.D. and A. F. Anglemier, Ph.D., Westport, Connecticut, 1964, The Avi Publishing Co. Pp. 472. ($3) A collection of papers on food chemistry, especially proteins, delivered at the Oregon University symposium last year.

ABSTRACTS ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

JANUARY, 1965 • VOL. XXXVIII, NO. 1

DRUG RESISTANCE IN PULMONARY TUBERCULOSIS

Analysis of the degree of bacillary resistance to the three commonly used drugs in tuberculosis therapy points up the clinical significance of even a low degree of resistance and the importance of susceptibility tests capable of detecting resistance, however slight.

An attempt has been made to determine whether bacteriologic, roentgenographic, or clinical deterioration occurs in patients with tubercle bacilli of low degrees of resistance to drugs in use as well as in patients with highly resistant bacilli.

The analysis was carried out retrospectively. All patients with pulmonary tuberculosis whose names were brought to the notice of the research laboratory from 1952 through 1957 were included, provided there was definite evidence of resistance to at least one of the standard drugs, there had been at least three months' treatment with standard drugs, and the bacteriologic, roentgenographic or clinical information was available.

A separate analysis was made for each of the three standard drugs—streptomycin, PAS, and isoniazid.

For each patient the degree of drug resistance was classified as high, variable, or low. Seventy patients who had 187 treatment courses were analyzed.

In 91 per cent of the treatment courses, the pretreatment roentgenogram showed far-advanced disease. In 71 per cent, the disease was considered chronic; in 22 per cent, chronic with acute spread; and in 3 per cent, acute. The mean duration of treatment per course was 8.23 months. Only treatment given while the patient was in the hospital has been considered.

For treatment courses including streptomycin and PAS, the duration of treatment at risk of change was somewhat greater in patients with organisms of a high degree of resistance than in those whose bacilli remained at a low degree of resistance; that is, those in the high resistance group had a longer period of treatment during which deterioration could occur. With isoniazid, the longest duration at risk was in the combined low-degree groups.

Deterioration Incidence

Bacteriologic deterioration was demonstrated in 12 of 16 patients with a high degree of resistance to streptomycin, in 5 of the 6 patients with organisms of a variable degree of resistance, and in all 7 patients at risk whose organisms were of a low degree of resistance. The incidence of deterioration by at least one criterion (bacteriologic, roentgenographic, or clinical) was 68 per cent in the high-degree group, 60 per cent in the variable group, and 82 per cent in the low.

Of the 19 patients at risk with a high degree of resistance to PAS, bacteriologic deterioration was demonstrated in 16. The numbers at risk in the variable and low-degree groups were small, the incidence of deterioration being 3 of 3 and 2 of 2, respectively. The incidence of deterioration by at least one criterion was

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Sheila M. Stewart, Ph.D. and J. W. Crofton, M.D. *The American Review of Respiratory Diseases,* June, 1964.

68 per cent in the high-degree group, 83 per cent in the variable group, and 75 per cent in the low-degree group.

Of the 36 patients at risk with organisms of a high degree of isoniazid resistance, 29 showed bacteriologic deterioration, compared with 2 of 4 in the variable group, and 13 of 16 in the low-degree group. Twenty-three of the 66 patients in the high-degree group deteriorated clinically, 3 of 8 in the variable group, and 7 of 22 in the low-degree group. The incidence of deterioration by at least one criterion was 70 per cent in the high-degree group, 50 per cent in the variable group, and 64 per cent in the low-degree group. The incidence of *improvement* when the organisms were resistant to all of the drugs was 41 per cent, 50, and 29 for the three groups.

The incidence of deterioration was therefore at least as high in patients with organisms of a low degree of resistance to any of the three drugs as in those with highly-resistant bacilli.

Improvement occurred in a number of patients when their bacilli were still susceptible to at least one of the drugs and in some patients even when their bacilli were resistant to all the drugs in use. The improvement was more frequently shown by clinical criteria than by roentgenograph.

If bacilli of a low degree of resistance are of less clinical significance than those of a high resistance, it might be expected that deterioration associated with organisms of a low degree of resistance would occur later. However, in 10 of the 34 courses analyzed, deterioration occurred before the detection of resistance to streptomycin; in 8 of 23, deterioration occurred before the demonstration of resistance to PAS; and in 10 of the 63 courses which included treatment with isoniazid, deterioration occurred before resistance to that drug.

In 7 patients treated with drugs in adequate combinations, organisms were shown to be of a low degree of resistance to at least one drug and fully susceptible or of a low degree of resistance to at least one other before the start of treatment. Failure under treatment showed that the low degrees of resistance recorded before treatment were clearly of clinical significance. Two of these patients were primarily infected with bacilli resistant to one of the standard drugs.

Choice of Test Important

The evidence from the present analysis shows that organisms which are only slightly less susceptible to streptomycin, PAS, or isoniazid than normal strains are as important clinically as those which are highly resistant. Deterioration during treatment frequently occurred in patients harboring bacilli of a low degree of resistance. It is therefore of primary importance that any tests used for the detection of drug resistance should detect these organisms with low degrees of resistance.

The main problem in assessing the efficiency of a susceptibility test is that there are many strains of bacilli in which resistance will be detected by virtually any method of testing. But there are others in which resistance is not detected if unsatisfactory tests are used.

Even a slight decrease in drug susceptibility in strains of tubercle bacilli is of clinical significance.

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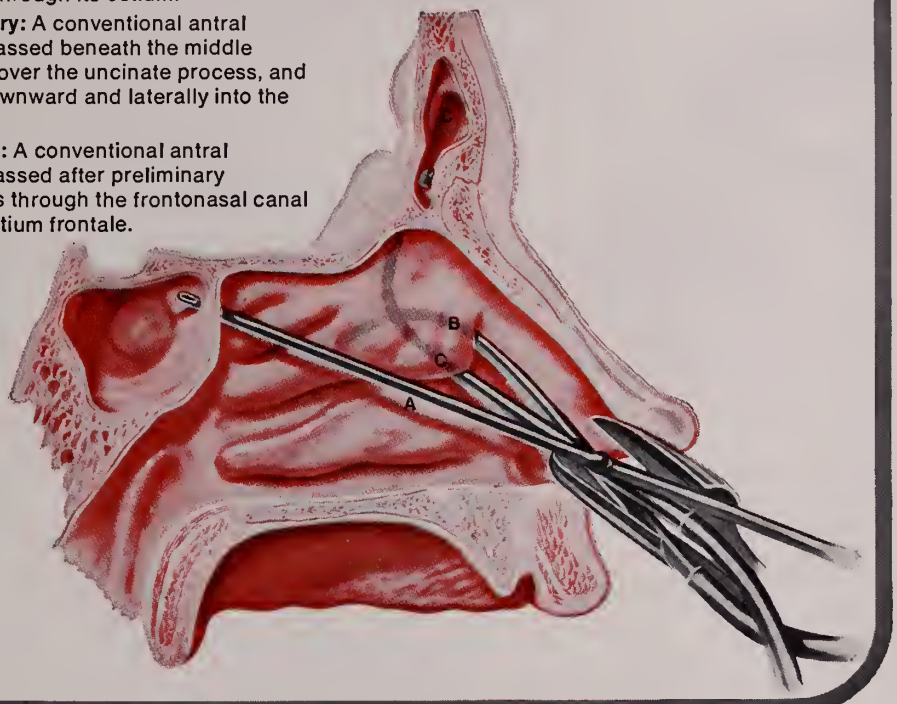
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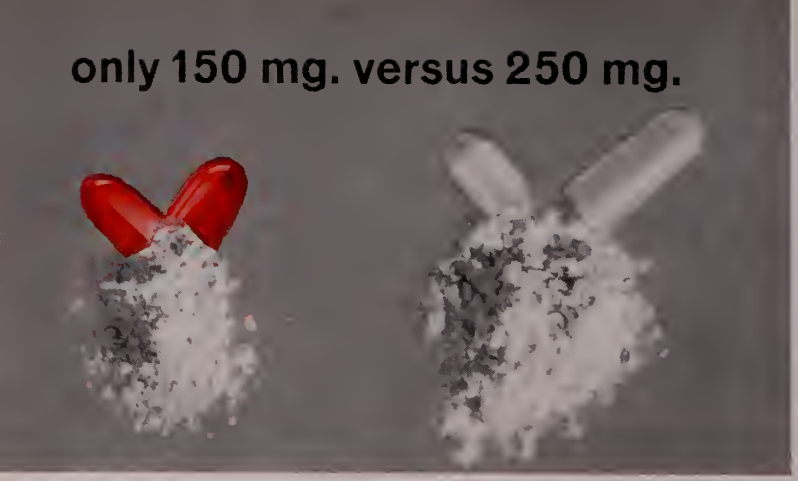
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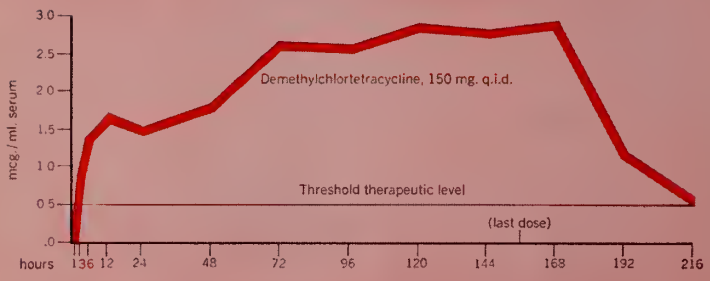
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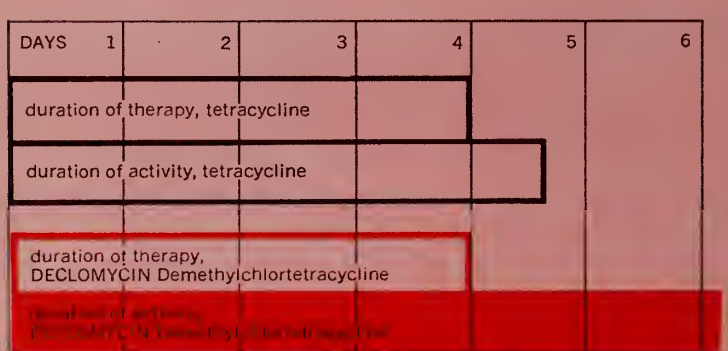


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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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FEBRUARY, 1965 Vol. 62, No. 2

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REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

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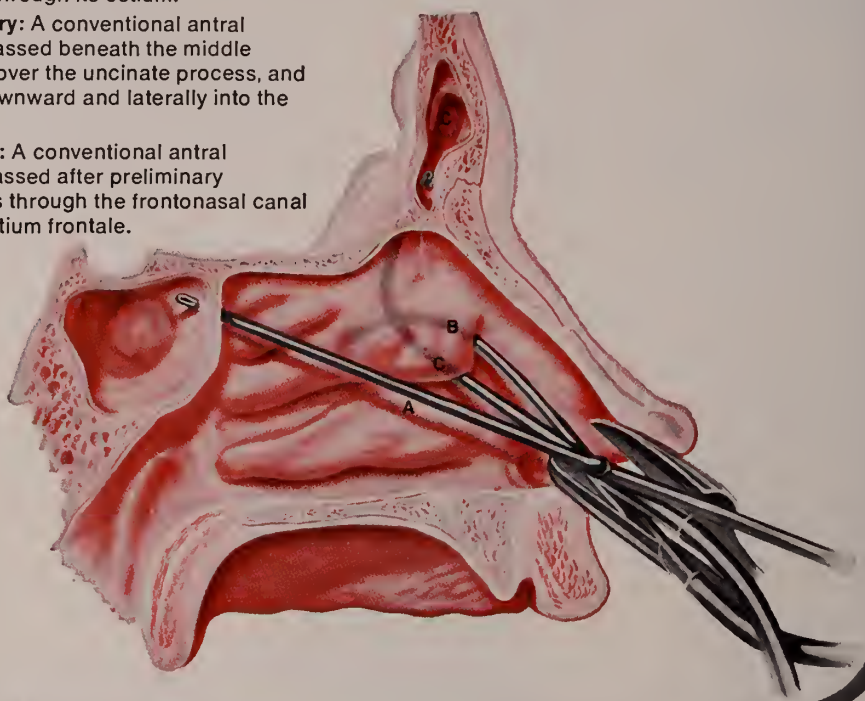
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*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

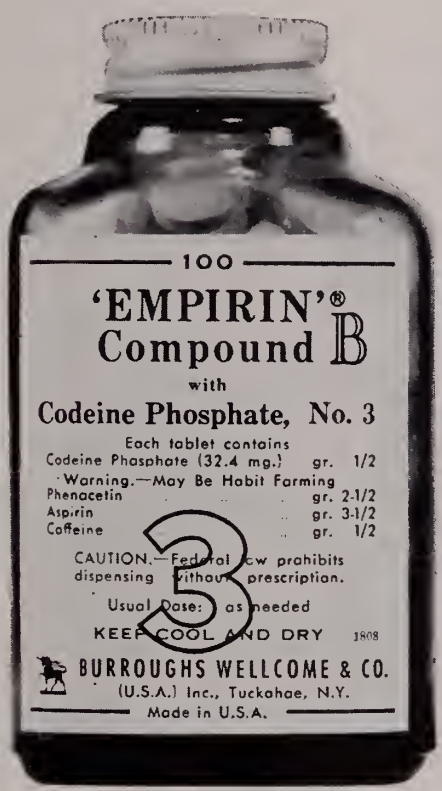
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(1) *Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955.* (
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No. 12, Dec. 1963.

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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone pl reserpine in moderately severe and severe hy tension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Mont June 14–19, 1964.

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*This one at Oak Creek, Castle Rock, Arizona

References: 1. Hock, C. W.: Clin. Med. 8:1932, 1961. 2. Marks, L.: Am. J. Gastroenterol. 27:180, 1957. 3. Palmer, W. L., and Kirsner, J. B.: Therapeutics in Internal Medicine, 2nd ed., F. A. Kyser, Ed., Hoeber, New York, 1953, p. 368. 4. Ryan, J. P., Jenkins, H. J. and Robinson, S. M.: J. Pharmaceut. Sciences 53(9):1084, 1964. 5. Vollmer, H.: Arch. Neurol. & Psychiat. 43:1057, 1940. Abst. J.A.M.A. 115:333, 1940. 6. Wharton, G. K., Balfour, D. C., Jr., and Osman, K. I.: Postgrad Med. 21:406, 1957.

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EDITORIALS

Au Revoir But Not Good-By

Cryotherapy offers contingent hope for those who believe in the revival of the body after death. On page 75 of this issue, we review a book called *The Prospect of Immortality* by Robert C. Ettinger. Mr. Ettinger's thesis is that a man dies little by little, that even after clinical death some cells are alive for a fairly long time. If at this point the body is frozen at low enough temperatures, it might be possible to preserve the tissue indefinitely without deterioration. Mr. Ettinger is convinced that (at the rate by which our science is advancing), we will—in two or three centuries—know how to remove and replace almost any diseased tissue. If, now, the person (or should one say the cadaver) is kept in deep freeze for that period of time and then thawed out, it should be possible to replace the diseased organ and thus effect a resurrection.

Many people are convinced of the immortality of the soul, and many believe in a non-corporeal life after death. This thesis, however, is much less ethereal. Here we are told that there might be corporeal life after death. Smith[1] quotes Andjus and Lovelock, who reported long-term survival of rats who had been frozen ice cold. Kenyon[2] says that he has frozen dogs until heartbeat and circulation have ceased and then thawed them out so that they recovered. Smith[1] himself has frozen hamsters to the point where half the water in the brain had changed to ice and where the hamsters were literally frozen stiff. Yet they recovered to normal activity. Jacob[3] showed that viability in a sperm cell could be maintained after cooling it to minus 272 Centrigrade—and then warming it up. Last year, Lillehei[4] demonstrated that the stomach removed from the body could remain healthy and functioning in an artificial medium for some time.

What staggers the imagination, however, is the image of a civilization where most who die would be stored in freezers. Would a life insurance company pay off on a policy if the person who died were placed in deep freeze? Legally, is such a person dead? Or, for that matter, is he a person or a corpse? Again, the economies of this culture are interesting. Ettinger estimates that once the freezers were available, it would cost only $200 a year to service the vault. All you would have to do would be to invest $6,700 at 3 per cent—and this would produce $200 a year forever. Since some people couldn't find $6,700, Ettinger suggests that "arrangements will be handled at first by individuals, then by private companies, and later by the Social Security System." (King and Anderson, apparently, reach everywhere . . . Cradle to the grave—and beyond.) Social Security or some other welfare agency would have to do it; otherwise the penalty for not servicing the freezer would be death. When we reach the freezer-centered culture, failure to put a deceased relative into the freezer would become murder. This would enable the indigent to escape both death and taxes. (This is Ettinger's idea, not your editorialist's.)

Where would you stack all the bodies? By the year 2260, the author estimates that there will be 40 billion bodies (or people, or freezees) to be stored, if not stacked. However, the deserts of Africa and Australia, the jungles of South America, and—appropriately—the frozen tundra of the arctic and antarctic have plenty of room. The freezer will not be getting visitors regularly, since you can't risk a rise in temperature by opening the door. So it will not matter whether the locker is in Antarctica, Africa, or Australia.

It all sounds like science fiction. But so, at one time, did escalators, moon shots, and television. Sooner or later, Mr. Ettinger thinks, we will come to freezing. And then, he concludes, "For the first time in history, it will be au revoir, but not good-by."

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[1]Smith, A. U.: *Biologic Effects of Freezing*, Williams and Wilkins, 1961, Baltimore.
[2]Kenyon, J. R. *et. al.*: Lancet 2:41 (July 1959)
[3]Jacob, S. W.: *Transplantation Bulletin* 5:428 (1961)
[4]Lillehei, R. C. *et. al.*: Journal of the American Medical Association, 183:861 (March 9, 1963)

The Support of Medical Research

Less than 5 per cent of the money spent annually for medical care, goes into medical research.* And today, less than 8 per cent of all research money is allotted to medical research. Fifteen years ago the figure was 6 per cent, so there hasn't been much improvement. It is necessary to cite these figures before alarmists start wringing their hands at huge federal grants for medical research.

On the face of it, the federal slice of the pie does seem excessive. In 1947, Uncle Sam spent $27 million to finance medical research; now it grants $924 million a year. Thus, the amount expended by the federal government has skyrocketed by 3400 per cent. Indeed, of the total tab for medical research, the U. S. Government picks up 64 per cent and the pharmaceutical industry 26 per cent, leaving only 10 per cent for foundations or private sources. Pessimists suggest that as federal largesse increases, private support must fall. This, however, is not the fact. To be sure, federal support multiplied 34 times in 15 years. But private contributions have shot up by 900 per cent in that same period.

Another factor here is the site of the research. Such activities conducted in a federal installation are, naturally, subject to closer Government supervision than research in a private clinic or university. At the beginning of the century, practically all federally supported research was conducted in federal hospitals, clinics, and agencies. In 1947 the proportion of federal research funds allocated to "outside" agencies had risen to 36 per cent. Know what it is now? Almost 75 per cent!

Considering how high the stakes are, our investment in medical research does not seem too high. As was noted at the top of this editorial, less than 8 per cent of all research money goes into medical research—not, surely, an excessive amount. And since three-fourths of federal research money is dispensed to nonfederal installations, there seems little likelihood of Uncle Sam's calling the tune.

All of this presents us only with numbers. Quantity, however, is no substitute for quality. The Government's reluctance to interfere with the scientist is not an unmixed blessing. Research conducted in a University department, private clinic, medical school, or local agency may suffer from the limitations of self-monitoring. Perhaps a little "outside" supervision might help.

Still unresolved is the problem of research personnel. On the one hand is the need for the scientifically trained mind, accustomed to rigorous, self-imposed discipline. On the other hand, so far as medical research is concerned, is the need for the practitioner—the man who makes the human contact with the patient, the man who must deliver the fruits of research to the sufferer, the man who, when all is said and done, must be the cutting edge of research before any real advance can be made.

America's medical research profile is healthy: well-financed but by no means over-inflated; supported by a good balance of benefactors, though still in need of more qualified and dedicated personnel.

*Thanks to the University of Chicago's Health Information Foundation for the statistical underpinning of this editorial.

A Doctor Must Make Decisions

In this world of "sharing" and "togetherness"—not to mention "democracy"—there is a temptation for the doctor to give the patient the facts and let him make the decision. He has a hernia. So you explain the pros and cons of leaving it alone, wearing a truss, or having a surgical repair. Thus, you are sharing responsibility . . . And being democratic. But, when a man is sick he doesn't want the added burden of making decisions. The physician who can make crisp and fast decisions is a more effective doctor than the one who evades his responsibility and forces on the sick and anxious patient an additional load. A frightened child wants poppa to tell him what to do. And a sick adult is a frightened child.

Some experts now question the thesis that an increased rate of cell division is the hall-mark of cancer.

The Changing Face of Cancer

Robert D. Barnard, M.D./Lakewood

In order for a somatic cell—that which comprises the bulk of all tissues—to divide, it must first double its content of the "genetic substance," desoxyribonucleic acid (DNA). The act of DNA replication requires an expenditure of thermodynamic energy in the form of adenosine triphosphate (ATP), which is the medium of exchange in all biologic transactions: nerve conduction, muscle contraction, glandular secretion, and even the maintenance (in warm-blooded animals) of homothermicity. Biochemists have denominated the "raw commodity" of energy procural as the glucose molecule. "Conversion" of this by the power-plants of the cell (the mitochondria) results in the freeing of the ATP "funds" for energy purchase.

There are two alternative modes of glucose-metabolic processing by which it could be converted to the "high energy phosphate" of ATP: (1) In *aerobic glycolysis*, glucose is oxidized to carbon dioxide and water through the ostensibly necessary agency of molecular oxygen; or (2) the glucose molecule can be split *anaerobically* into two molecules of lactic acid. Most cells elect process (1) (or perhaps have evolved into it) because it is the more efficient of the two. *Seventeen times as much ATP* is generated by aerobic glycolysis than an equivalent of glucose would yield anaerobically. Examples of a preference for process (2) are limited to the obligate anaerobic bacteria and most cancer cells.

Forty years ago, Warburg[1] suggested that cancer cells were characterized by an anaerobic metabolism, which could be obligate or facultative. He suggested, too, that cancer was caused by any agent which might injure the normal oxidative-chain mechanisms of the cell and force a reversion to a more primitive non-oxidative metabolism.*

Warburg's experimental demonstration of the difference between cancer and "normal" tissues in this regard was by means of the gaseous-exchange microtechnics. The comparatively low respiratory quotients of cancer cells were confirmed independently in many laboratories as a generality rather than the type of definitive particularization that cancerologists were hunting. There were annoying exceptions to the unique differential. Thus, the normal retina behaved (respiration-wise) as though it were cancer, and there was the usual polemic over the possibility of confusing cause and effect. What gave Warburg's theory the coupe-de-grace was the subsequent elucidation of the role of "high energy phosphate bonds," such as characterize ATP, in general metabolism and the realization that rapid cellular growth and division rate could never accrue from the meager quantities of energy yielded by anaerobic glycolysis. Cancer in general is a hyperproliferative disorder, and most interested parties readily saw the necessity for rapid growth and accelerated division rate for cancer to be what everyone knew it to be.

The electron microscope was applied in cellular studies in 1940 and one of its primary applications was in comparison of cancer cells with their normal homologous cells of origin. This led to an annoying degree of confirmation of

* Though not strictly germane to the present thesis, "phylogenetic-throwback" theories of cancer have something to commend them, and the philosophically-minded reader might wish to read the highly technical, involved but closely-reasoned, Lawson Tait Memorial Prize Essay[2] by D. Lang Stevenson, who marshals much evidence for this theory. The pragmatic reader may be more impressed by the fact that Mr. Stevenson is, and has been for years, an actively practicing surgeon.

a situation which had earlier reared its ugly head through the microscope oculars of those using conventional cytologic technics. The most astonishing finding was that the numbers of mitochondria and the sites of ATP production were markedly *less* in cancer cells. It was a fact that wouldn't go away. It posed an inconsistency. And the whole history of science is consistent in having shown that just such inconsistency is the rotted timber which topples the framework of "established" doctrine.

The emergence of a fateful inconsistency operates to direct attention to other similarly implicatory inconsistencies which, though painfully present, are repudiated by the conscious mind. Many observers question the hyperproliferative nature of cancer. Rapid growth and proliferation are not requisites for tumor formation. Normal epithelial cells always lie continguous to a lumen, or surface, from which they constantly desquamate. Displace them from such a situation and intumenscence is inevitable, even if the division rate drops to one-hundredth that of the normal. Cell population dynamic studies by myself[3] and others[4], [5] had shown that in leukemia there was definite cellular *hypoproliferation,* though the application of such data to the general cancer problem could be challenged by those who felt that leukemia might be an unrepresentative species of the malignant neoplasm†.

But the critical blow to the hyperproliferation thesis of cancer came about as the result of a new experimental technic which will be detailed below. There is now a tendency among cancerologists to discount any conclusions drawn from the transplanted animal variety as being merely a "tissue culture in a live test tube" and quite incomparable to human cancer.

†The recent agreement among cancer agencies to concentrate on leukemia is based on other considerations: (1) It is regarded as a "disseminated" cancer from the outset, and (2) viral theories proposed for the origin of cancer can be tied in with the undisputed virus nature of the fowl leucoses. I am committed to a better elaboration of the real characterization of the leukemias as a prototype of malignancy in general, as flowing out of scientific analysis rather than—as the similar pronouncements on the efficacy of the cytotoxic, antimetabolite anticancer drugs—a matter of settling a scientific point by official agency edict. R.D.B.

When autochthonous cancers are exposed to triatiated thymidine (TT) they take up much less of this nucleoside than do comparable normal cells. A cell cannot divide until it has doubled its DNA content. Thymidine is unique to DNA; RNA contains uridine in its place so that (with some limitations) TT will be taken up at a rate and to an extent proportioned to the rate and extent of DNA synthesis. The tritium "label" on the thymidine is, of course, simultaneously incorporated into the newly formed DNA; and since it is radioactive, the sites of DNA formation will write an autoradiograph when placed in contact with a photographic film.

The technic has been widely adopted; it is in use throughout the world and has been the subject of at least a thousand published reports since its introduction in 1958. Solidly-based conclusions flowing from observation around them has already led to considerable soul-searching and may seriously affect the clinical oncologic practices of the future. To enumerate:

1. No human cancer cell has been found to have as rapid a division rate as its homologous normal cell of origin.
2. The effect of any cytotoxic, radiamimetic drug—whether of the alkylator, pyrimidine-analogue, or "spindle-poison type"—is to reduce the rate of cell divisions in proportion to that cell's normal reproductive potential.
3. The antimitotic effect of cytotoxic drugs is always much more profound on *all* proliferative cells of the body (liver, renal tubular epithelium, buccal and gastro-intestinal mucosa and hemopoietic marrow) than it is on *any* type of autochthonous cancer yet studied. And practically no form of cancer remains unstudied by this technic.
4. Sensible proliferation acceleration may follow the administration of androgenic and/or estrogenic steroids and of the corticosteroids, so that ameliorative effects of these hormones in certain patients with cancer may reside in bases other than presumed "hormone-dependence ablation."

A proposal has been made seriously that the approach to tumor therapy through cell proliferation *stimulation* could hold more promise than the currently accepted mode of attempted mitosis suppression.[6]

The management of the patient with cancer is a technology, and the enumerated facts leave appreciable impact marks.

"Obviously," to quote Oppenheim,[7] "if cancer is not a situation of increased cell division rate, those modalities applied for the specific purpose of achieving cure by slowing down or abolishing cell division become irrational. The use of antimetabolites as a kind of definitive therapy must now be seriously questioned."

The practice of a technology is also a continual squaring of one's attitude with the fallout from experience. It is within the province of the practicing physician to adjudicate the propriety of that conclusion.

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Triage: First Step In Disaster Care

At its December 1964 session, our Board of Trustees received a report from the Committee on Disaster Medical Care. The section dealing with triage was considered as offering material that every physician should be familiar with, and is published below for the interest and use of our members.

In a mass casualty procedure, patients are swiftly sorted into four basic treatment categories. This sorting process is technically known as *triage.**

The purpose of prompt triage is to indicate treatment priorities. The basic objective of medical care in time of mass disaster is, of course, to return the largest possible number of persons to activity—and to get them back as rapidly as possible.

Persons receiving immediate medical care will be those for whom a short period of treatment or a relatively simple procedure will significantly improve the prognosis. Severity of injury, per se, is *not* the determining factor in assigning treatment category. Some persons with serious injuries may be placed in the "immediate treatment" category if a relatively brief or simple procedure may alter an otherwise poor prognosis or avoid serious future disability. Patients with injuries, whether major or minor, whose treatment would demand considerable professional time must be placed in a delayed or expectant treatment category and receive only emergency or supportive care until sufficient personnel and facilities are available to render the more time-consuming definitive treatment.

In mass disaster situations, speed and *competence in sorting are the single most important medical professional functions.* Since the two fundamental components of sorting are *diagnosis* and *prognosis,* this function should be assigned to the most experienced surgeon present. He may be assisted by other professional persons who will be able to classify many patients whose treatment categories can be easily determined.

At triage, all patients are assigned to one of four treatment categories:

I. Ambulatory Treatment
II. Immediate Treatment
III. Delayed Treatment
IV. Expectant Treatment

Sorting is a continuous process to be repeated in all areas of the hospital so that patients are constantly being changed from one treatment category to another as justified by circumstances. Thus, patients placed in the Delayed Treatment Category will be moved into the Immediate Treatment group as rapidly as personnel and facilities become available. Similarly, patients receiving active treatment who are subsequently found to have conditions needing prolonged or intensive care may have to have this treatment delayed until more professional personnel become available.

*The French word for culling or picking out. The verb is *trier,* and the term was originally used in commerce, to indicate classification by selections. The English verb "try" has the same origin.

Psychiatric disability is often responsive to rehabilitative effort—and here the doctor's leadership is needed.

Aid for the Psychiatrically Disabled*

Richard E. Gordon, M.D., Ph.D., J. Lawrence Evans, M.D., and Katherine K. Gordon, M.A./Englewood

Every year the number of persons receiving monthly benefits under the disability insurance program of the Social Security Administration increases. For the past two years the rate has begun to decline. But from 1957 through 1963 the increase was ninefold—to 1.4 million persons. The average monthy disability payment now is $91, which is 18 per cent higher than the average social security payment to retired workers. The monthly cost to the taxpayer is 92 million dollars; it is compounding by over 1 per cent per month[15].

Disabled persons get higher benefits because the average disability beneficiary is five to eight years younger than old-age retirees. Often the disabled person has received a better education, acquired more vocational skills, and has earned higher wages.

To be considered disabled does not mean just that the applicant cannot perform his old job, but that he *cannot do any other substantial gainful work;* moreover, "the illness or injury must have lasted for 6 full calendar months and must be a condition from which the person is not expected to recover in the forseeable future."[12,14,16] Physicians in every field may be interested in an analysis of applicants who seek these benefits on psychiatric grounds.

Stephens and Lerner[14] recently reported that 40 per cent of the claimants whose cases they reviewed were neurotics. Only 13 per cent were schizophrenics. Throughout the nation, the applications of two out of every ten schizophrenics are denied. Among neurotics this denial ratio is seven out of ten. Actually, 53 per cent of the psychiatric beneficiaries are schizophrenics and only 18 per cent are neurotics.

Stephens and Lerner say that they are surprised at the pessimism of many psychiatric consultants who believed that 65 per cent of neurotics were totally disabled.

They noted[14] without comment that "psychiatrists in economically distressed areas are especially prone to find applicants disabled."

This report will review the case histories of patients sent to the present authors for psychiatric consultation by the Disability Determinations Service (DDS). These cases are *not* a representative sampling of social security psychiatric disability claimants. Consultative examinations are secured on only 34 per cent of "mental cases." The remaining 66 per cent include the institutionalized persons requiring constant supervision and other severely impaired patients. However, the following data and case histories illustrate many problems. This analysis may help the physician appreciate what psychiatric treatment and rehabilitation can offer now and in the near future.

Method

The records of 86 Social Security Administration (SSA) psychiatric disability applicants seen by the authors were reviewed and analyzed. The findings were tabulated and compared to data from the 2,000 SSA disability claimants reviewed by Stephens and Lerner,[14] and those of 923 Group Health Insurance (GHI) psychiatric patients studied by Avnet,[1]

*From the Englewood Hospital and from Wagner College, Staten Island.

whose treatment was paid by their insurance. The three groups were compared by age, sex, diagnosis, previous treatment, recommended treatment, and (for GHI patients) by outcome of treatment. Stress-factor scores were calculated for a sample of 20 disability claimants. The scores were compared to those of 810 psychiatric outpatients treated in private office practice. (Certain personal history items appear more in the lives of psychiatric patients than in the histories of normals; the stress-factor score is obtained by counting the numbers of these items.)[4,8]

Results

Age: There were no important age differences between the sexes of SSA disability applicants. GHI treatment patients as a group were much younger than disability applicants (see Table 1).

TABLE 1

Ages of SSA Psychiatric Disability Applicants and GHI Psychiatric Treatment Patients

Age	GHI per cent	SSA per cent
29 and under	16%	9%
30-39	33	19
40-49	27	21
50-59	19	33
60 plus	5	18
	100%	100%
N -	923	86

Diagnosis: There were comparable ratios of neurotics among the GHI treatment patients and the two groups of SSA disability applicants (see Table 2).

Previous Psychiatric Treatment: Significantly fewer GHI patients (38 per cent) had previously had psychiatric treatment as compared to 51 per cent of SSA disability applicants. However, only 23 per cent of neurotic SSA applicants had previously had any psychiatric care.

Sex: Males predominated in both groups. Among 661,000 disabled workers receiving SSA benefits in the nation in 1962 for all medical disorders, 82 per cent were males. However, among the SSA applicants for psychiatric disability in this study, 37 per cent were women. This sex difference is statistically significant. More women than men were diagnosed "neurotic" in both the GHI report and the present study; more males were considered to be suffering from personality disorders.

Stress Factor Scores: The scores for SSA disability applicants was 3.4—less than the average score of 4.3 among 810 psychiatric patients in office treatment who were studied previously.[8]

Treatment: Among the GHI patients treated, neurotics were the most responsive to treatment. Those with personality disorders were the least responsive. The same pattern was found among treatment recommendations for SSA applicants. The present authors were more optimistic about the possibilities for rehabilitating neurotic SSA disability applicants than were the psychiatric consultants whose evaluations Stephens and Lerner[14] reviewed (see Table 3).

TABLE 2

Diagnostic Categories of SSA Psychiatric Disability Applicants and GHI Psychiatric Treatment Patients

	GHI			SSA (Stephens & Lerner[14])	SSA (Gordon & Evans)		
	Men	Women	Combined	Men & Women Combined	Men	Women	Combined
	percentage			percentage	percentage		
Psychoneurosis	36%	48%	43%	40%	30%	54%	37%
Depression†				16			
Psychosis	19	20	20	13	42	24	37
Personality Disorder	18	11	15	7	19	12	17
Other	27	21	22	24	9	10	0
	100%	100%	100%	100%	100%	100%	100%
N-	447	463	910	2,000	53	33	86

†Stephens and Lerner[14] included a category in which they combined both neurotic and psychotic depressions.

TABLE 3

Recommendations for Treatment and Rehabilitation

	Recovered or Improved GHI per cent	Recommended for Treatment and Rehabilitation (Stephens & Lerner) per cent	(Gordon & Evans) per cent
Psychoneurosis	79%	31%	77%
Depression*		48	
Psychosis	75	24	28
Personality Disorder	61	16	25
Other	71	29	38
Average	75%	31%	43%

* Includes both neurotic and psychotic depression

Twenty-six per cent of the SSA applicants were chronically ill psychiatric patients who could easily be considered permanently disabled. All had been institutionalized for psychiatric care.

Case Histories

These examples are offered as illustrations of disability applicants sent for psychiatric consultations who, with treatment and rehabilitation, might have regained their ability to work. Yet, only one, Miss D, had sought or been referred for psychiatric help; she responded favorably.

Socio-economic Stress

Mr. A., a 60-year-old clerk, retired from work on the advice of his employer after a kidney stone operation. Subsequently his pension was drastically reduced by the company because of circumstances over which he had no control. While he was an abstainer, his wife was an institutionalized chronic alcoholic. He had no physical or mental troubles—other than worry about his reduced income. At the time of the examination, he could not sleep well because of concern over finding a job and getting more money.

He was actively looking for employment and was well-qualified for office work. If he could not find work he would lose his home. He would not live with his married daughter, whose husband, a college graduate and successful executive, was the son and grandson of well-to-do professional men.

Mr. A's memory was good. He displayed no abnormal ideas or behavior. He stated emphatically that he would never attempt suicide.

Impression: (1) Financial insecurity. (2) Anxiety reaction, moderate.

Comment: This patient has never been referred for, sought, nor been hospitalized for mental problems. He needs assistance for realistic economic and social problems, but they are *not* caused by a primary psychiatric difficulty. He is not psychiatrically disabled. He is willing and able to work. (Calculating the total number of stress factors in his life, his score was three.)

Situational Problems

Mrs. B was a 59-year-old married woman who had had psychological complaints—fainting, weakness, depression, nervousness—off and on for four years prior to her examination, ever since her children married and moved away from home. She was new to her community and had few friends. She was chronically lonesome, and lacked the background and experience to adjust herself readily to her new home. She and her husband lacked understanding of her needs. She had never sought social or family counseling, nor psychiatric treatment, and had never been a patient in a mental hospital.

The patient showed no abnormalities of thought or behavior. She was coherent and logical in reciting her story. Her affect suited the content of her thoughts.

Diagnosis: (1) Acute situational maladjustment. (2) Neurotic depressive reaction.

Comment: This patient has a very real social difficulty arising from her lonesome position in life. She is not able to do much to help herself, although her family possibly could be of assistance if they were shown how. She might benefit from working, but her motivation to work is not great. Financial aid would be of little help to her with her problem; she needs counseling and assistance in finding a useful, respected place in her new community. (Her stress factor score was three.)

Conversion Reaction

Mrs. C. was a 48-year-old, pleasant, friendly woman with a long history of medical and surgical problems which began with the death of her father from kidney disease when she was seventeen. He was then only 46. Her mother died a few years later of a strangulated hernia, also at the young age of 46. The family's financial difficulties required that the patient quit school to work. She told us that her

brother had a heart attack. Her daughter was hospitalized, and received electric shock therapy for an acute depression following an auto accident and concussion. Her husband had an ulcer, and a sister had a cerebral hemorrhage and "spasms of the heart."

The patient's operative history included: an appendectomy, "scraping and raising the womb" and removal of tubes, hysterectomy and operation on a vaginal cyst; tumor of the breast removed; and an operation for "dropped bladder," ovarian cyst, and adhesions. She said that she almost died on the operating table during the last procedure when her heart "kicked out."

She laughingly guessed that she had a really "bad case of complications" with "loads of files" about her in her doctors' offices. She also has suffered from "peritonitis, asthma, bronchitis, headaches, sinus trouble and spasms of choking." She remembered x-ray treatment for arthritis of the spine, an enlarged lung, another ovarian cyst, and bad headaches. She would have continued to add to the list if given encouragement.

A complete report from her physician indicated that actually she was in excellent physical health.

Mrs. C. seemed to be enduring her multiple ails heroically. She slept late mornings. Her husband, whom she "loved dearly," prepared most of his own meals. Her daughter-in-law helped with heavy housework. The patient visited friends, family, and doctors regularly. She seemed to have cordial relationships with them all. Sickness benefits helped her out until they expired on each of six or seven occasions. On the whole, she frankly stated that her life was good.

Diagnosis: Conversion reaction

Comment: This woman's problems are related to past difficulties, but not to any present serious personal ailments. This type of psychological disorder sometimes responds to psychotherapy, but not to financial compensation, which had tended to reward and perpetuate her neurotic functioning. This patient is not truly disabled, but has a rather full life. Although she obviously has neurotic problems, she by no means requires constant supervision nor institutional confinement. (Stress factor score was six.)

Schizophrenic Reaction, Residual Type

Miss D. was a 28-year-old, fairly attractive, unemployed school teacher. She had recently spent eight months in a state mental hospital.

She became mentally ill after teaching four years, was hospitalized, and received electro-convulsive therapy. After leaving the hospital, she worked in a bakery, but was soon discharged from her job. Unable to return to teaching, she held various office jobs.

She had psychotherapy at intervals during the period before her second hospitalization. She had been going out with a young man for nine years, but he decided to marry someone else. She began to argue with her family, to masturbate openly in the house, felt worthless, and refused to work or see her friends. She was soon hospitalized.

Her father, aged 58, was "a real neurotic . . . he ribs you to pieces." He was in business, but the business was sold. After that he "did all sorts of things," his last job being as a janitor in a library. He has had two strokes. Her mother, aged 52, "has had ulcers and high blood pressure. She is a good woman, but a nervous person and somewhat on the martyr side." A brother aged twenty, "won't live at home, he can't stand it."

At college she was withdrawn and stayed in her room. All through college, her father kept telling her that she was "spending his inheritance money." In 1958, while teaching, she began to be upset. She took tranquillizers but began to lose discipline in the classroom, neglected her appearance, and grew frightened and anxious. When we saw her, she told us: "I walk in a fog. No one seems to understand what it is. I fight depression. I feel lost. I should be married and have a couple of kids, or be earning my own living." She has a great deal of difficulty in getting up in the morning. She feels inferior and can't make decisions. She adds, "I feel very frightened. I feel different." She was oriented in all spheres.

Diagnosis: Schizophrenic reaction, residual type.

Comment: This patient returned to the psychiatric consultant (JLE) for psychotherapy and tranquillizers. She was able to calm her anxieties, rebuild her self-confidence, and obtain employment in her profession. She was discharged as much improved after fourteen sessions, approximately one year after beginning office treatment. (Her stress factor score was five.)

Character Disorder

A final example will illustrate some of the further complications involved in psychiatric compensation. Mr. E, an eighteen-year old adolescent, sought a psychiatric examination, accompanied by a relative who was a municipal official. He and his family wanted the psychiatrist to fill in forms they provided so that he might receive payments as totally medically incapacitated. He had a lengthy history of antisocial behavior, inattendance at and expulsion from school, and poor work record. His staying out late at night in the company of ne'er-do-wells, his failure to get up in the morning, and arriving late to work or not at all resulted in his repeatedly being fired. Thereupon he collected unemployment insurance until payments ran out.

He had a long juvenile court record for delinquent behavior. His parents had been separated for years. His father was violently killed under questionable circumstances. The young man asserted that the army had found him acceptable for active duty, but his mother would not allow him to enter service. Tests revealed low normal intelligence, and provided no evidence of serious psychiatric disorder nor of organic brain damage. His intellectual functioning was handicapped primarily by lack of education.

Diagnosis: Character disorder—antisocial personality.

Comment: This youth's background history and behavior are more typical of those who run afoul of the law than of psychiatric patients. He is not ill, and medical assistance is not indicated, nor probably would it be of any help. His disorder is not of the type that generally responds to psychiatric treatment, unless applied in connection with firm management by those with actual control over his life. His problems are related to his lack of training to persevere with school or jobs, and his association with delinquents. Instead of solicitation and coddling, he needs to be made to keep regular hours and to apply himself to work. (Stress factor score: four.)

The Physician's Responsibility

Society cannot ignore the needs of people who through no fault of their own—natural catastrophe, technologic advance, or illness—suddenly find themselves in financial need. In some cases the claimant's employer went out of business, in others the applicants were replaced by machines or younger employees. These men tried but could not find work. They had serious economic problems and needed help from society, but they were not seriously ill psychiatrically. Yet they were referred for disability assistance on psychiatric grounds.

Persons haunted by obsessions, house-bound by phobias, made miserable by compulsions may not be able to solve their problems unaided. They may be too paralyzed by anxiety to seek and hold a decent job. To cope with serious emotional problems is not easy, yet many people who are encouraged and helped to try can succeed. Avnet[1] reports in the Group Health Insurance research project on the insurability of patients that 75 per cent of claimants for psychiatric treatment improved or recovered. Remarkably, the average cost per patient of the GHI treatment program was only $186!

The GHI-treated patients were younger than the applicants for SSA disability payments seen by the authors, and youth is often associated with better prognosis with psychiatric treatment. However, in the GHI treatment program, only the oldest adult patients (over 65 years of age) were less responsive to psychotherapy than the other age groups, and only one disability applicant seen by us in consultation was 65 years old.

Other features about disability applicants suggest that many might respond to psychiatric treatment and vocational rehabilitation. Disability beneficiaries must have five years of work credits in the ten years before disability began. Thus, very seriously ill persons who have never been able to hold a job effectively are automatically ineligible. Patients who have worked regularly at some time and have a good education and vocational skills, as is the case with many psychiatric disability beneficiaries, have a good prognosis for rehabilitation from emotional disorder.[14] Moreover, the average number of life history stress-factors in a sample of the SSA patients was less than that of 810 psychiatric patients, most of whom responded to office treatment.[8]

One schizophrenic claimant—Miss D, whose case history is described—came for private treatment, and was able to resume full-time work as a teacher. Another applicant, who had been hospitalized twice for recurring depression, returned to work with antidepressant medication alone. The present authors believe that over *three quarters of the neurotic applicants upon whom they performed consultations might have been rehabilitated.*

Why Not Treatment?

If many psychiatric patients can be rehabilitated, why then are people considered disabled without receiving a serious trial at treatment? There are many possible answers. First, effective rehabilitation and treatment of seriously ill psychiatric patients are new technics with which many have had only limited experience, and in which they naturally have little confidence. Second, facing and overcoming emotional difficulties involves hard work both for the patient and for the therapist. Most people who become psychiatric casualties do not know how to help themselves. They usually require competent medical and psychological assistance. On the other hand, no special competence is needed to offer an emotionally dis-

turbed person money when it is available; or for him to accept compensation for his suffering.

Third, traditionally there has been a conflict between the advocates of rehabilitation and those who struggled to achieve cash benefits for the disabled. The latter have felt threatened when rehabilitation was offered as an alternative to income maintenance; some of the former believed that cash benefits were unnecessary, destructive of character, and a bar to rehabilitation.[17]

To this day, the claimant not only must prove his disability but also must defend himself against efforts to belittle it by those seeking to hold down costs. This adversary approach produces a delay in starting rehabilitation, prolongs the period of recovery, and limits its extent; time is wasted waiting for a condition to stabilize, and in collecting medical and other information for evaluating a case. Moreover, the patient who is busily proving his disability and its permanence comes to believe he is incurable; this naturally opposes efforts towards his rehabilitation.

Women Applicants

Why were proportionately more women referred for consultation for psychiatric conditions than for physical illnesses? Many women nowadays have more responsibility than they have been trained to handle. Many develop psychoneuroses and acute psychoses as a result of the stress of new expectations for which they were hardly prepared, added onto deeper problems. Others (especially those with older children) are bored with housework and child care; they get depressed when they feel trapped in a position whose status is declining in America.

On the other hand, women psychiatric patients who have worked at some time in their lives are often responsive to treatment—significantly more so than those who have never worked. Moreover—and this is a key point—getting them to return to work or to another form of constructive, socially useful activity can be a major factor in their recovery[6,7,8]!

Rehabilitation and Payments

If organs, wounds, and bones are going to heal, they usually will, whether the patient wants them to or not—but not always. Hirschfeld and Behan[2] have shown that many neurotics are especially prone to develop compensible injuries as a result of industrial accidents. They often come to physicians, not to be cured, but to retain a provable incapacity.[10]

For the emotionally ill person to get well, he must value achievement as a means of gaining compensation and respect. However, knowledge that he can always fall back upon disability payments can help relieve his anxieties and give him a sense of security, while he meanwhile exerts a continuing effort to face and conquer his fears. To the security which comes from social insurance can be joined the opportunity for rehabilitation. The objectives of disability insurance and rehabilitation are mutually consistent; they fulfill distinct but complementary functions.[9]

Rehabilitation is encouraged by the Disability Determinations Service. Disability determinations are made in almost all states by state vocational rehabilitation agencies.[20] A number of programs are designed specifically to help return the claimant to normal functioning. Among these measures are: automatic consideration of *all* applicants for possible vocational rehabilitation services; continuation of cash benefits while a beneficiary tests his work capacity; and suspension of benefits if he refuses rehabilitation services without good cause. To date, some 28,000 beneficiaries have returned to work or have otherwise recovered enough medically to permit their leaving the nation's benefit rolls.

The accumulation of past and present stresses may overburden an individual and contribute heavily to his psychosomatic or emotional disability; however, his ability to regain control and to function effectively and happily are related to his skill in coping with life's problems, to the availability of dependable human resources for aid and support, to his economic and social security, and to his opportunity to work or otherwise perform useful services.[3,4,6,11] Persons whose efforts to adapt

are rewarded will continue to try to help themselves. Those who meet little but frustration eventually give up trying. Then they may become chronically withdrawn, embittered and violent, tense and/or suspicious.

A mental patient who has an unrewarding home life often cannot get well without a decent job and regular earnings. He cannot be cured in a social vacuum; he must have new satisfying experiences to replace the agonizing ones that made him sick. At a job that he likes, the patient can begin to control painful emotions and divert his abnormal thoughts by concentrating on his work. Gradually, by succeeding at important duties, he can restore a sense of personal accomplishment, and can begin to develop feelings of well-being and self-control.

What Can The Physician Do?

First, physicians can keep informed about the possibilities for rehabilitating psychiatric patients. The hopeful developments in this field (such as the success of the GHI study) indicate that physicians can feel greater confidence in supporting rehabilitation services, facilities, and personnel. Second, they can consider the conditions under which rehabilitation and cash benefits are not in conflict—namely, when both are aimed as much as possible at the patient's recovery. Third, since rehabilitation should begin immediately, physicians, government agencies, employers, insurers, mental health workers, and lawyers should all make the patient's return to productive living their primary goal, with income maintenance considered part of the rehabilitation process. Fourth, physicians can maintain an optimistic attitude with psychiatric patients, offering them hope and helping motivate them for rehabilitation. Fifth, physicians can help supervise psychiatric treatment and rehabilitation facilities for the disabled, paying special attention to their expenses and effectiveness. Many psychiatric patients have enormous dependency needs; it is very easy for them and their therapists to get involved in prolonged, expensive programs which foster this dependency. The GHI program avoided this dilemma by limiting the amount of funds and the number of treatments available to each patient.

Summary

This paper has provided an analysis of characteristics of 86 applicants for psychiatric disability payments for whom consultations were obtained by the Disability Determinations Service. Many claimants were diagnostically similar to patients who benefited from psychiatric treatment at modest cost under the GHI private insurance plan and from private outpatient psychiatric care.

Three-fourths of neurotic applicants for disability payments might have been rehabilitated inexpensively, and returned to full employment. However, less than one-fourth sought psychiatric help or were referred by their physicians for treatment. The implications of these observations were discussed.

Acknowledgements

Dr. Henry Davidson and Dr. Joseph Lerner reviewed this manuscript and made many useful criticisms and suggestions. The staff of the State of New Jersey Rehabilitation Commission and of the Division of Disability Determinations and the Office of Vocational Rehabilitation of the Social Security Administration were very helpful.

An extensive bibliography of citations appears in the author's reprints.

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General practitioners and pediatricians will be interested in an intensive refresher course in pediatrics from May 24 to May 28, inclusive, under the sponsorship of The Children's Hospital of Philadelphia. Tuition is $150. More details are available from the Post Graduate Education Committee of The Children's Hospital, 1740 Bainbridge Street, Philadelphia, Pa.

An understanding of the biochemistry and pharmacology of the oral antidiabetics will also provide clues to the physiology of the disease and to sugar metabolism in normal subjects.

The Action of Oral Hypoglycemic Agents*

LeRoy A. Pesch, M.D./New Brunswick

Twenty years before the famous experiments of Banting and Best and twenty-five years prior to the crystallization of insulin by Abel, orally administered agents were used in the treatment of the diabetic state. In 1901, Williamson[1] reported that salicylate could reduce glycosuria in diabetes mellitus. While the mechanism by which salicylate reduces the hyperglycemia, glycosuria, and ketonuria of diabetes is not known, it probably represents the first clinically effective oral hypoglycemic agent. Because of the occasionally bothersome side effects encountered with the administration of large doses of salicylates, however, the drug has not been used to any great extent. Hundreds of agents have been tried in an attempt to find an effective oral insulin substitute. However, only in recent years has this search been rewarding.

Useful Oral Hypoglycemic Agents

Many chemical compounds can lower blood sugar by poisoning one or another of the organs of the body. One such agent is 2:4-dinitrophenol, which was misused as a reducing agent in the 1930's. Although this has also been tried in diabetes[2], it is not an accepted form of chemotherapy. Modern oral hypoglycemic agents are limited to two basic classes of compounds: the sulfonylureas and the biguanides. The subsequent discussion of mechanisms of action will be limited to these two groups of drugs.

The Diabetic State

The diabetic state is the condition resulting from relative or total insulin lack. This condition is manifest as the variety of clinical findings which derive from an altered state of metabolism. Since diabetes is a disease of intermediary metabolism, the changes of diabetes are reflected quantitatively to the greatest degree in the three parts of the body that contribute the bulk of metabolic activity; liver, adipose tissue, and muscle. The role of the liver is to store glucose as glycogen and to release carbohydrate into the blood stream as needed. In addition, the liver is geared to synthesize glucose from other substances and also for oxidation of fatty acids to provide energy for this process. In essence, then, the role of the liver in carbohydrate metabolism is to regulate glucose homeostasis.

Enzymatically, muscle is a much simpler tissue than liver. Essentially, muscle is a substrate *consuming* organ. Muscle metabolizes glucose, ketone bodies, and fatty acids to provide energy. Finally, adipose tissue functions to synthesize and release fatty acids. These fatty acids are synthesized largely from glucose.

In the diabetic state, metabolic alterations lead to increased levels of glucose, fatty acids, and ketone bodies in the peripheral blood. In the diabetic liver, glucose-6-phosphatase levels are increased while glucokinase activity is de-

*From the medical school of Rutgers University in New Brunswick. This paper was read at the Annual Meeting of The Medical Society of New Jersey in Atlantic City on May 19, 1964.

creased. This leads to a continuous production of glucose in the face of hyperglycemia. The muscle in the diabetic state suffers from impaired glucose utilization, and as a consequence derives almost all of its metabolic energy from the metabolism of ketones and other non-glucose materials. Adipose tissue in the diabetic state suffers from relative carbohydrate deprivation, a condition which stimulates the release of fatty acids. Many additional subtle alterations also occur in diabetic metabolism.

Metabolic Effect of Insulin

If it can be assumed that the primary defect of diabetes is the metabolic consequences of relative or total insulin lack, then knowledge concerning the way in which the Beta-cells of the pancreas synthesize, store, and release insulin becomes central to understanding the nature of diabetes and to successful and rational treatment. It is in this area that an understanding of the mechanism of action of the oral hypoglycemic agents has both strengthened the therapeutic armamentarium of the clinician and added a new dimension to understanding the endocrine function of the pancreas.

Evidence available at this time supports the following sequence of events in the release of insulin from the pancreas. First, high levels of blood glucose trigger the release of insulin from the Beta-cell into the pancreatic venous blood. Histologically, this release is accompanied by degranulation of the Beta-cells. It has thus been postulated that the granules of the Beta-cell represent stored insulin. In many adult diabetics, however, the stimulus of hyperglycemia fails to initiate this release even though Beta-cell granulation and bioassays of extractable insulin indicate the presence of adequate stores of the endogenous hormone.

Oral Hypoglycemic Agents

Administration of the sulfonylureas by either the oral or parenteral route causes a reduction in the blood glucose concentration in all non-diabetics and in some diabetic subjects. The response in healthy subjects is determined by the drug potency and is related to the plasma drug level. If the extra-pancreatic effects of these drugs are considered first, then the intestinal absorption and renal excretion of glucose are likely sites to be considered. However, none of these drugs has been shown to have a significant effect on the absorption of glucose from the gut of experimental animals. Likewise, there is no evidence that these drugs in any way alter the renal threshold for glucose. A second possible mechanism would involve an effect of these agents on the rate of glucose utilization by peripheral tissues. The majority of the available clinical and experimental evidence has failed to demonstrate an effect of the sulfonylureas on peripheral glucose utilization. No additional *in vitro* studies have shown any consistent effect on the intermediary metabolism of insulin-sensitive tissues. On the other hand, the initial observation of Loubatières[3] that the presence of some pancreatic tissue is essential for the sulfonylureas to exert a hypoglycemic effect has been repeatedly confirmed. The additional observation that, to date, the sulfonylureas have not been shown to exert an effect on the blood glucose levels of severe alloxan-diabetic rats, together with the fact that mildly alloxan-diabetic animals do respond, clearly indicates that the hypoglycemic response to these agents depends on the presence of intact cells of the pancreas. The well supported hypothesis, again suggested originally by Loubatières[4], that the hypoglycemic effect of the sulfonylureas is due to a stimulation of insulin release from the Beta-cells of the pancreas has now been generally accepted. Studies by Duncan and Baird[5] have clearly and consistently demonstrated the release of a hormonal principle, presumably insulin, from the pancreas after administration of sulfonylureas. A few investigators have been able to detect an increase in insulin-like activity from the blood plasma of patients receiving sulfonylureas, using sensitive bio-assay technics. A consistent increase in insulin-like activity can be detected in pancreatic vein blood following administration of these drugs. In addition, there is experimental evidence that administration of sulfonylureas is followed by a decrease in the pancreatic content of insulin. Finally, administration of a sulfonylurea causes degranulation of the Beta-cells of the pancreas. While none of these observations in and of themselves establish the mechanism for the

hypoglycemic response to the sulfonylureas, taken together they do support the idea that these drugs stimulate insulin secretion. The intracellular biochemical events responsible for this effect are completely unknown. There is certainly no evidence that these drugs stimulate the synthesis of insulin.

In addition to the studies summarized, there are a great number of reports indicating actions of the sulfonylureas on a variety of tissues and metabolic processes. However, the interpretation of these studies is complicated by a lack of understanding of the effects of insulin itself, and final interpretation must await a more precise understanding of insulin action. The one additional, and perhaps significant, effect of these agents is an effect on the liver which results in diminished glucose release.

Action of the Biguanides

The biguanides have a different mechanism of action than the sulfonylureas. The first notable difference is that there is no hypoglycemic effect in non-diabetic subjects. Also, in contrast to the effects of the sulfonylureas, the biguanides lower the blood sugar concentration in alloxan-diabetic, depancreatized, eviscerated, and hepatectomized animals. In addition, *in vitro* studies have demonstrated an increased uptake of glucose by diaphragm and liver in the presence of DBI. These observations clearly indicate an entirely different mechanism of action for the biguanides, probably due to an interference with intermediary carbohydrate metabolism. Steiner and Williams[6] have implicated a partial block in the respiratory chain with a consequent inhibition of Krebs cycle activity and increased anaerobic glycolysis to explain these effects. Such an effect would explain the hypoglycemia by diminishing glucose production by the liver and is compatible with the other metabolic effects of the biguanides.

Potentiation of Leucine Hypoglycemia

Finally, it is of interest to describe briefly some recently reported studies done by Fajans and a group at the University of Michigan[7]. It has been known that oral administration of L-leucine, an amino acid, causes a fall in the blood sugar of some children with idiopathic familial hypoglycemia and in patients with functioning islet-cell tumors of the pancreas. Fajans and his group[7] demonstrated that leucine hypoglycemia could be induced in normal subjects following the oral administration of sulfonylureas, and that this hypoglycemia was caused by the release of insulin from the pancreas. An illustrative case would be a healthy subject pre-treated with chlorpropamide and given oral L-leucine. The fall in blood glucose to hypoglycemic levels is associated with a dramatic rise in plasma insulin content. Goldner[8] was one of those to show that L-leucine-sensitive hypoglycemia in islet-cell tumors is due to hyperinsulinemia. Such investigations and observations are increasing our knowledge of the physiology underlying a more thorough understanding of the diabetic condition.

Summary

There are many unanswered questions regarding the mechanisms of action of the oral hypoglycemic agents. An appropriate summation was recorded by Claude Bernard[9] in 1877 long before the study of these compounds was undertaken. "If in the field of diabetes all the pathologic obscurities have not yet been completely elucidated, this is because the knowledge of the normal function is still imperfectly understood. Only by increasing our knowledge of the physiologic aspects shall we find the basis for the formulation of an adequate pathologic theory and by this dual approach we shall eventually master the control of the morbid phenomena. Physiology defined in this framework will be the only certain guide to the understanding of the pathology and the therapy of diabetes mellitus." Almost in response to these prophetic words by Dr. Bernard, the oral hypoglycemic agents are providing a key to unlock not only stores of insulin from the pancreas but also stores of information concerning vital physiologic processes.

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Good results in pollinosis in children are reported by following this carefully spelled out regime.

Management of Pollinosis in Children*

William B. Nevius, M.D./East Orange

Of the allergic diseases of the respiratory tract in children, hay fever accounts for 44 per cent, while bronchial asthma and allergic rhinitis account for 38 and 18 per cent, respectively. The capacity to develop allergic disease is inherited and passed on to future generations. In families where both parents have allergic symptoms, half of their children usually exhibit allergic symptoms by the age of 10; and three quarters, by the age of 30. If only one parent is allergic, half of the offspring will exhibit allergic symptoms by the age of 30.

The symptoms of hay fever in children are similar to those in adults: itching and watering of the eyes, itching and watering of the nose, sneezing, and itching of the palate. These symptoms, which occur regularly at certain seasons, are due to the pollens in the air at those seasons. The symptoms are the same regardless of the offending pollen.

In this climatic zone, there are three distinct pollen seasons. The first, the *early spring* season, occurs from approximately March 15 to May 15. It is due to the tree pollens, the most common of which are ash, beech, birch, elm, hickory, oak, poplar and sycamore. Symptoms are usually mild, last about three weeks, and frequently do not require treatment. The second, or *late spring* season, extends from May 15 to early July and is due mainly to the grass pollens, timothy, orchard, June, red top, and sweet vernal. In this area, symptoms usually do not become annoying until about May 20 to 25, and are largely over by July 1. Plantain usually accounts for the rare patient who has symptoms in July, i.e. between the two main seasons.

The third and most important season is *in the fall,* usually beginning a few days before or after August 15 and extending until the first killing frost, which is usually about October 1. This is commonly called the *weed season,* as symptoms are due mainly to giant and dwarf ragweed. A child may have one or any combination of these types, although the incidence in descending order of importance is the ragweed season, the grass season, and then the tree season.

Another possible cause of allergic symptoms is mold. The most common molds are Alternaria, Aspergillus, Hormodendron, and Penicillium. While their presence in the air is not limited so strictly into seasons as the pollens, they do tend to be more prevalent in the summer, especially during hot, damp weather. Consider molds in cases which do not conform to the usual pollen seasons, do not respond well to usual treatment, and which are worse in hot, humid weather.

Hay fever can develop as early as one year of age. It usually manifests itself by persistent sniffles and rubbing of the eyes and/or nose. It is relatively common by four or five years of age. If a child has a persistent, watery discharge in April, June, or September, and if one or both parents are known to be allergic, and if the child's symptoms tend to recur each year at the same season, he probably has hay fever. The next step is to attempt to confirm the tentative diagnosis by skin testing with properly standardized pollen extracts. The usual strengths are 10, 100, and 1,000 protein nitro-

*Read May 18, 1964 at the Annual Meeting of The Medical Society of New Jersey.

gen units (P.N.U.) per cubic centimeter, and they are given in the skin of the upper arm intradermally with a 26 gauge ⅜ inch needle, a separate syringe and needle being used for each extract and about 1/50 cc. being injected. In our clinic we commonly use the following extracts for skin testing:

A mixture of the 8 trees mentioned previously, a mixture of timothy and orchard grass, plantain, and a mixture of giant and dwarf ragweed.

It is not necessary to test with all spring pollens, for if a patient reacts to one, he usually reacts to all. In some clinics, timothy alone is used for the testing and treatment of *all* spring pollen cases, but better coverage is obtained by a combination of timothy and orchard. If a test is positive, wheal formation with redness and itching occurs within a five to ten minute period. The reactions are recorded as negative, slight, moderate, and marked. A moderate test shows redness and itching; a marked test shows redness, itching, *and pseudopod* formation. It is important to grade the results of the tests for the patient's degree of sensitivity as well as his dosage schedule are determined by his classification. This is done as follows:

Strength of Extract†	Result	Class
1,000	Marked	C
100	Marked	B
10	Marked	A
1	Marked	AA

The patient is then treated by a series of hyposensitization injections, according to a dosage schedule suitable for his class, provided the tests conform to the patient's pollen season. As an example, if a patient has symptoms only from August 15 to frost, and his tests are positive to both ragweed *and* timothy and orchard, he is treated only with the ragweed extract and not the timothy and orchard. All patients do not feel they need to go to the trouble of being treated. Some can escape to pollen free areas, such as the White Mountains of New Hampshire, and others obtain relief at the New Jersey shore—especially when a sea breeze is blowing. Others obtain sufficient relief from antihistamines of which Dimetane® and Teldrin® are particularly effective and still others equip their bedrooms (or perhaps the entire house) with air conditioning. If an individual has to remain near home and has annoying symptoms, his best chance of relief is in hyposensitization treatments. Examples of typical schedules for hyposensitization are as follows:

Beginning Dose in each class	Class AA 2 units	Class A 5 units	Class B 10 units	Class C 10 units
Average number of injections	7	12	17	13
Usual top dose	50 units	500 units	2500 units	2500 units

The injections are timed so that the top dose is given just before the beginning of the pollen season. Injections are usually given every four to seven days, and a top dose of 2500 units is rarely exceeded. When the season begins, the patient can usually be kept comfortable with injections every ten or fourteen days until the season ends, at which time they are reduced to once every four weeks through the rest of the year until the next pollen season arrives. This is known as the perennial treatment, generally considered the simplest, most efficient, *and safest* for the patient.

When giving the injection treatments with pollens, the physician must *always* be on the alert for a constitutional reaction. This is usually due to giving (accidentally) too large a dose, allowing too long an interval between doses, or giving too large an increase. A constitutional reaction is characterized by one or more of the following symptoms: wheezing, urticaria. tightness of the chest, itching of the scalp or palms of the hands, and a frequent hacking cough. Appropriate treatment must be instituted *immediately*. This consists of applying a tourniquet around the arm above the site of the pollen injection, and the subcutaneous injection of 0.25 cubic centimeters to 0.30 cubic centimeters of epinephrine hydrochloride 1:1,000 *above* the tourniquet or in the other arm. (In a well managed office, the tourniquet, epinephrine, and syringe are instantly available on the treatment table.) Symptoms will usually subside in a few minutes, and the tourniquet may gradually be loosened. It is mandatory to keep the patient in the office for 15 minutes after an injection, for, if a severe constitutional reaction is going to occur, it will do so in that time. If it occurs later, it can usually be controlled with antihistamines.

†Expressed as protein nitrogen units per cubic centimeter.

If the patient is cooperative and the injections are properly given, results are usually very satisfactory. One can safely promise 85 per cent of improvement in 85 per cent of cases. When the child gets on his once-a-month schedule, it is a small chore for him to continue his injections indefinitely.

Two other methods of treatment have recently come into prominence. These are repository therapy and alum-precipitated pyridine pollen extracts. In repository therapy, the pollen extract is mixed with an emulsion usually made of mineral oil; and enough is given (in terms of protein nitrogen units) at one or two injections to protect the patient for the entire season. This has been promoted particularly by E. A. Brown[1] of Boston and has been used at numerous centers throughout the country. In skilled hands, it appears to give satisfactory results in all age groups including children. But it has certain drawbacks. It is absolutely necessary to obtain a very fine and even emulsion, and the technic of obtaining such a fine, smooth, and well-maintained emulsion requires rather elaborate and expensive equipment, highly skilled technicians, and considerable time. The procedure appears to be too complicated for a busy allergy clinic in the average community hospital which has the usual problem of shortage of funds and skilled personnel. Even when it is possible to obtain a suitable emulsion, difficulties are encountered, such as local reactions of erythema and swelling, annoying abscess and cyst formation, constitutional reactions, and asthmatic attacks.

Alum-precipitated pyridine pollen extract was introduced by Fuchs and Strauss[2] and tested on a large series of patients by Gaillard and others.[3] This differs from other pollen extract in that *non-defatted* pollen was extracted with an extracting fluid containing one part of an organic solvent pyridine and one part of an aqueous solution of 0.9 per cent sodium chloride or 0.3 per cent sodium bicarbonate. This differs from all other pollen extracts because the lower molecular fractions (which are highly skin sensitive but weakly antigenic) are washed away and eliminated. This product is slowly absorbed because the alum precipitate must first be dissolved by tissue metabolites. Because of this slower absorption, fewer doses given at higher rates of dosage increase, and achieving greater total nitrogen levels, may be given. For example, in patients of Class C sensitivity, a level of 10,000 protein nitrogen units could be reached in 7 doses, materially fewer than the 13 required for Class C cases treated with aqueous extracts. Gaillard[2] has reported considerable success with these APP‡ pollen extracts and has found them particularly useful in supersensitive patients. Considering the smaller number of injections required, the greater freedom from reactions, and the good results obtained, they seem to be well suited for children and warrant further trial.

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‡Aluminum-precipitated pyridine.

572 Park Avenue

Prizes for Diabetes Papers

An intern, resident, or research Fellow in a hospital is eligible to submit a paper to the New York Diabetes Association in its prize contest. To enter, send in an abstract of the paper—the abstract to be not more than 250 words. Get the abstract in by March 31, 1965, sending it to the Prize Essay Committee, New York Diabetes Association, at 104 East 40 Street, New York, New York 10016. Further details will then be sent. The paper must represent original thinking, writing, or research in the field of diabetes.

26492

New Jersey is a long way from the Rocky Mountains, but not, as these medical officers show, from Rocky Mountain Spotted Fever.

Rocky Mountain Spotted Fever in New Jersey*

Elliot M. Eisenstein, Captain, MC

and Basil G. Delta, Major, MC/ Fort Dix

Perhaps because of its very name, and certainly because of its uncommonness, Rocky Mountain Spotted Fever is seldom, in New Jersey, considered as the cause of a febrile illness with rash. During 1963 only one case was reported to the State Health Department.[1] This was in a 50-year-old woman from Toms River. It was never proved serologically. Actually, the incidence of the infection in the Middle Atlantic seaboard states is believed to be second only to that in the Rocky Mountain area.[2] Since we had the opportunity to treat four cases at Walson Army Hospital in New Jersey, we felt it important to report them in order to remind physicians of the local occurrence of this condition.

Case One

A 9½ year old girl was hospitalized with a 48 hour history of fever, headache, anorexia, and vomiting, and with a rash developing on the day of admission. She gave a history of tick bites during the two weeks preceding the onset of this illness. She was a well nourished, alert, feverish, slightly dehydrated, and somewhat toxic-appearing child. Oral temperature was 101.8. Pulse and respiratory rates were 110 and 26 per minute respectively, and regular. Blood pressure was 108/62. There was moderate voluntary guarding of the abdomen and a generalized macular rash extending over the palms and soles.

Urinalysis, serum electrolytes, proteins, and BUN were normal. Leukocyte count was 15,000/cu.mm. with 78 per cent neutrophiles, 20 per cent lymphocytes, and 2 per cent monocytes. Hemoglobin was 13 Gms per cent, hematocrit 38 per cent. Blood culture was negative for bacterial growth.

Upon admission, she was started on tetracycline 300 milligrams every six hours. (This was based on 40 milligrams per kilogram of body weight per day.) She received aspirin, intravenous fluids (for dehydration), and, of course, bed rest. On the first hospital day, her temperature reached a high of 104.6, and then over the ensuing 72 hours fell to normal by lysis. By the third day, headache and abdominal pain had subsided, hydration was improved, and oral fluid intake became adequate. After seven days of antibiotic therapy, the girl was discharged from the hospital afebrile and asymptomatic with no further skin rash. Her leukocyte count and differential became normal.

Case Two

A 3½ year old girl was hospitalized with a three-day history of fever, vomiting, diarrhea, and a maculopapular rash. There was a history of tick bite ten days prior to the onset of these symptoms. She was, on admission, an alert, febrile, toxic-appearing, irritable, moderately dehydrated girl covered with a generalized maculopapular eruption with lesions over the palms and soles. Rectal temperature was 99.4. Pulse and respiratory rates were 86 and 22 per minute, respectively, and regular. Blood pressure was 94/56.

Urinalysis, serum electrolytes, proteins, and BUN were normal. Blood culture was negative for bacterial growth. Leukocyte count was 16,500/cu.mm. with a differential of 79 per cent neutrophiles, 19 per cent lymphocytes, and 2 per cent monocytes. Hemoglobin was 12 grams per cent. Hematocrit was 36 per cent.

On admission she received oral tetracycline 150 mgm ever six hours (40 mg/Kg of body weight per day). She also received bed rest, aspirin for fever and headache, and intravenous fluids for dehydration. On the first day her temperature spiked to 105, rectally. It slowly returned to normal over the next four days. Following the resolution of the fever, she rapidly improved and the rash faded. She was discharged from the hospital on the seventh day in good condition, at which time her antibiotic therapy was discontinued.

Case Three

A 9-year-old boy had a history of tick bites for five weeks. When he developed a fever and rash, the attending physician administered tetracycline, based on 30 milligrams of the drug per kilogram of body weight. Four days after the first dose of tetracycline, he was admitted to the Walson Army Hospital. He had a temperature of 103 at the time of admission. Physical examination at that time was unremarkable except for a fading generalized macular rash mainly over the trunk and lower extremities with lesions on the palms and soles. Urine analysis was normal. White

*This material has been reviewed by the Office of The Surgeon General, Department of the Army, and there is no objection to its publication. This review does not imply indorsement of the opinions advanced or recommendations made.

blood cell count was 9,300/cu.mm., with a differential of 47 per cent neutrophiles, 48 per cent lymphocytes, 1 per cent monocytes, and 4 per cent eosinophiles. Hemoglobin was 12.3 Gms. per cent, hematocrit 39 per cent.

Following admission the patient was continued on tetracycline, 250 milligrams every eight hours. For the 48 hours of his hospitalization, the child remained afebrile and asymptomatic, and was discharged to continue three more days of treatment at home.

Case Four

A 15-month-old infant was admitted with a seven day history of fever, rash, and irritability. When first seen (at onset) he had a generalized rash sparing the palms and soles which was felt to represent an enterovirus exanthem. The child was treated symptomatically with salicylates, fluids, and rest. During the ensuing week the temperature rose daily to 102 or 103. The rash spread to involve the palms and soles. In the two weeks prior to the onset of the illness, the child had been exposed to ticks, but no definite tick bite was noted.

On admission, he was an irritable but well-nourished and well-hydrated boy in no distress. Rectal temperature was 100. A generalized rose-colored macular eruption was present also on the palms and soles.

Urinalysis was normal. Leukocyte count was 9,700/-cu.mm., with a differential of 34 per cent neutrophiles, 62 per cent lymphocytes and 4 per cent eosinophiles. Hemoglobin was 10.1 grams. Hematocrit was 32 per cent.

On admission, oral tetracycline was instituted in a dose of 62.5 mgm every six hours (25 mg/Kg of body weight per day). He remained afebrile throughout his brief hospitalization. On the third hospital day, the rash began fading, and he was discharged to continue receiving tetracycline at home for another three days.

Complement Fixation Tests

Acute (on the day of admission to the hospital) and convalescent (two to three weeks later) blood samples were drawn on all four children. Complement-fixation tests for Rocky Mountain Spotted Fever were done on the sera at Walter Reed Army Institute of Research, Washington, D. C. These sera demonstrated a diagnostically significant increase in complement-fixation antibody titer in the last three cases when compared with that of acute sera. In the first case, although the reaction was positive with both diluted sera, the complement-fixation antibody titer showed no demonstrable change between that of acute and convalescent serum.

The Communicable Disease Service of the Department of Medicine at the Walson Army Hospital also treated successfully a 25 year old soldier in August 1963, who, following tick bite, had a febrile exanthem strongly suggestive of spotted fever. The convalescent serum revealed diagnostically significant rise in Proteus "OX" antibodies.

A recent evaluation of all four children revealed no pertinent sequelae, attributable to rickettsiosis.

Discussion

History. Rocky Mountain Spotted Fever was first reported from Montana in 1873. Its transmission through the wood tick Dermacentor andersoni was proven in 1902. In 1909 Ricketts[3] described the disease-producing microorganism, and the following year separated the disease from the typhus group. In 1931 Dyer[4] *et al* recorded the occurrence of spotted fever in the Eastern United States and reported the transmission of the infection by the dog tick, Dermacentor variabilis. Comprehensive reviews on the subject have been written by Harrell[5] and Smadel.[6]

Clinical Features. Rocky Mountain Spotted Fever is an acute infectious disease, characterized by sudden fever, headache, myalgia, prostration, conjunctival injection, and a maculopapular eruption. After an incubation period of 3 to 12 days, the rash appears first on the extremities, and spreads rapidly to most of the body, including the palms and soles—and at times, even the face and the scalp may be involved. The cutaneous spots progressively become more distinct and may become definitely petechial. The fever ordinarily lasts two weeks, if untreated, and may rise to 105 or higher. As the disease progresses, mental confusion, restlessness, and lethargy may be noted. Major complications include pneumonia, hemorrhagic tendency,[7] myocarditis, skin necrosis, vascular collapse, encephalitis, and coma.

Pathology and Epidemiology

Pathologically in Rocky Mountain Spotted Fever there is a diffuse vasculitis with capillary thromboses and extensive extravasation of plasma and red cells.[5]

Epidemiologically, man is entirely an incidental victim to spotted fever. Man is not responsible for the maintenance of the infection in nature which is largely due to ticks and the animals on which they feed. Most of the natural hosts (rodents, dogs) show only inapparent infections, with no diagnostic gross lesions or distinctive febrile reactions.[3]

The definite diagnosis is confirmed *serologically*. The complement-fixation technic using Rickettsia rickettsii as antigen provides a specific diagnostic test. Complement-fixation antibodies usually appear during the second or third week in patients who receive no specific therapy, but may be delayed or absent in those treated early in the disease.[5] (This may have occurred in our *Case 1*.) The Weil-Felix agglutination reaction may be used as a diagnostic test for Rickettsial infection but cannot be used in the differential diagnosis among Rickettsioses. Significant reaction (a titer above 1 to 320) may not be obtained until convalescence has begun. In some patients no proteus agglutinins are produced.[3]

In the differential diagnosis, other rickettsioses, meningococcemia, typhoid fever, and measles should be considered.[8]

The causative micro-organism Rickettsia rickettsii gains entrance through the patient's skin. In this area the dog tick is the vector passing the organism in its blood or feces. Since the tick defecates at the time it bites, and since the bite is pruritic, the patient scratches tick feces over the excoriated bite site. Crushing of the tick between the fingers or the presence of tick feces on an abraded skin region may also result in infection. The disease is not transmissable from man to man. In the Eastern United States, the prevalent sex is female; age, childhood; and season, summer. Susceptibility to infection is general. One attack of Rocky Mountain Spotted Fever usually produces long-lasting immunity.

Treatment

Treatment is with either chloramphenicol (50-100 mg/Kg of body weight daily) or the tetracyclines (25 to 40 mg/Kg of body weight per day). The drug is given until the patient has been afebrile for 48 to 72 hours.[9] These medications should not be used indiscriminately on any patient with a rash. They are given when the total clinical picture strongly suggests a diagnosis of rickettsial infection. These antibiotics are rickettsiostatic in their action, and are most effective when given early in the course of the illness. They prevent further damage caused by the action of the micro-organism. They do not repair damage that has already occurred.[3] Supportive therapy should be designed to counteract the loss of body fluids and protein and the elevation of blood urea nitrogen due to widespread vasculitis. Good nursing care is essential. Combination of specific antibiotic with supportive corticosteroid therapy reportedly[10] gives promise of further modifying the severe effects of Rocky Mountain Spotted Fever as well as shortening its course.

Prognosis and Prophylaxis

The prognosis is related to the intensity of the cerebral and/or cardiovascular involvement.[6] The fatality rate, which rises with increasing age, averages 20 per cent in the United States among untreated cases.

Rocky Mountain Spotted Fever is a reportable disease. Isolation is not required. Terminal disinfection and quarantine are not practiced.[8] As prophylactic measures, personal hygiene and tick-control methods are important; vaccination is indicated for persons highly exposed to ticks because of their geographical location or their profession.[3]

Summary

Four cured cases of Rocky Mountain Spotted Fever in children have been reported. Epidemiologic and clinicopathologic aspects of the disease have been briefly discussed. The disease should be considered in the differential diagnosis of any febrile illness with rash. Early recognition and diagnosis coupled with prompt and intensive antibiotic and supportive therapy offer the best chance for a satisfactory recovery.

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Walson Army Hospital

An infected tooth usually drains through dental bone into the oral vestibule. Occasionally, as in this case, it can lead to a draining facial sinus.

Facial Sinus of Dental Origin

Woodrow S. Monica, D.M.D./Orange

Medical and dental problems are often intermingled. Sometimes a disability of dental origin presents itself as a medical complaint, so that the physician is taxed to make a diagnosis. Here is an example.

Case Report

A 50 year old woman complained to a physician about a "boil" in the right submental region. Her doctor lanced it. Subsequently, the lesion "oozed pus", and she went to another physician. He "removed the core" and dismissed her. The lesion "oozed pus and blood" intermittently for two years. During this interval, the "boil" became raised and enlarged. Fearing it was cancer, she saw an otologist. He took radiographs and did a biopsy. Finding no malignancy, he suggested periapical dental radiographs. I took them and noted a large (8 millimeter) chronic abscess on a mutilated lower right first premolar (see figure). With the physician's concurrence, I extracted



the tooth. Suppuration ceased the next day and the lesion rapidly cleared. It was all gone within two months.

310 Main Street

The Paul Pegau Pavilion

Underwood Hospital in Woodbury, New Jersey, is building several additions. The first new wing is to be called the Paul Pegau Pavilion. This is an accolade to Dr. Paul M. Pegau, one of South Jersey's most widely respected physicians. A 1925 graduate of the Jefferson Medical College, he joined the staff at Underwood the following year and was, indeed, one of the first staff doctors there. He has been closely identified with the rise of the hospital ever since. He was an original trustee of the Underwood Hospital. The Paul Pegau Pavilion is scheduled for completion in April this year and will accommodate 78 beds.

In the May 1964 JOURNAL, *Dr. Hoerner explained how to write a respiratory disability report. This paper does the same for a representative orthopedic disability.*

Disability Reporting: the Orthopedic Case

Earl F. Hoerner, M.D./Newark

In the May 1964 issue of this JOURNAL (Page 173) we discussed the medical reporting of a case of respiratory disability. Below we consider the technic of reporting an orthopedic impairment. Subsequent papers will deal with neurologic, cardiovascular, arthritic, and psychiatric disabilities.

Remember that each year New Jersey physicians prepare about 25,000 medical reports for disabled patients who have applied for social security disability benefits. Approximately half of these initial reports do not provide enough clinical findings to permit a determination as to whether the patient is "disabled" within the meaning of the social security law.

These disability determinations are *not* made by the Social Security Administration in Washington or Baltimore. They are made by an evaluation team in the State in which the patient lives. The evaluation team consists of a physician (in New Jersey, a practicing physician working part-time in the Disability Unit of the New Jersey Rehabilitation Commission) and a layman skilled in vocational evaluation.

The reviewing physician never sees the patient. He works entirely from the report of the attending physician and other written evidence to decide two things: (1) whether the patient has an impairment that qualifies him for disability benefits, and (2) whether rehabilitation services are feasible in his case. Feasibility of rehabilitation is always considered whether or not the patient qualifies for disability payments.

To reach a conclusion as to the severity, duration, and remediability of the patient's impairment, the reviewing physician needs clinical history, physical and basic laboratory findings, and functional capacity observations. Frequently this evidence is available in the treating physician's records and, on follow-up, is obtained from him. This follow-up, however, takes up the treating physician's time—and also delays the decision on his patient's case.

The treating physician who understands what is needed can supply the necessary information on his initial report and save his own time. Also, he thus speeds the decision on his patient's claim for disability benefits.

Let us now consider the case of Charles Billings.† Mr. Billings applied for disability benefits in October 1963. He told the Social Security office that he had to stop working after he injured his back in June 1963. He stated that he and another man were carrying a large piece of furniture when the other man dropped his end. Mr. Billings had the full weight of the piece unexpectedly thrown on himself. Following the accident he experienced back pain which became so severe that his physician, Dr. Parks, had him hospitalized in September 1963. Treatment has included traction plus a back brace, which he says is uncomfortable and of little help. He has a board under his mattress, he says, "to keep his vertebrae in line."

† A fictitious name, of course. All records are confidential.

Mr. Billings had completed high school and then became an apprentice to a cabinet maker. After a few years, he was able to open his own shop. He has been self-employed as a cabinet maker for 10 years, employing 4 carpenters. Before the accident he took care of all business details, supervised the help, and did some of the cabinet work himself. He said that now his wife is trying to run the business (not too successfully, he added) with the help of a senior carpenter, who will purchase the business if Mr. Billings doesn't improve soon.

Mr. Billings had always worked irregular hours, sometimes working as many as 70 hours a week. His gross earnings from the business in the past few years have been about $12,000 a year.

Mr. Billings lives with his wife and three children in a 7-room house. A teen-aged daughter handles most of the household chores while Mrs. Billings is at the shop. A maid takes care of the youngest child until the daughter comes home from school. Mr. Billings can take care of all his personal needs, but he can't help with any household work or gardening.

Mr. Billings drives his automobile only on short trips. During the interview in the social security office, he got up several times, put his hands on his back above the hips, and sort of flexed his body. He said this relieved his stiffness. He wasn't wearing the back brace. He explained that he wore it only when he expected to have to stand more than a few minutes. He walked out of the office normally at the end of the interview.

For diversion Mr. Billings reads, watches television, and on nice days watches the younger children at play outdoors. Mr. Billings stated that he hoped that his condition improved so that he could at least attend to the management end of his business soon. He said that he doesn't expect to be able to take on the full range of his previous responsibilities but he hopes to be able at least to avoid having to sell the business.

The attending physician, a private practitioner, was asked to fill out our medical report form. Here is the report, and here is how Dr. Parks filled it out. The material in italics below indicates what was printed on the form. The answers given by Dr. Parks appear in regular type.

1. *Physical measurements (height and weight)*: Not filled in by the doctor.
2. *History (when injury occurred, when applicant became unable to work)*: Not answered.
3. *a. Subjective symptoms*: pain in lower back and left leg.
   b. Objective findings: Positive myelogram.
   c. Indicate if applicant is ambulatory, bed-confined, hospital or house-confined: Not filled in.
4. *Diagnosis*: Possible ruptured disc.
5. *a. Treatment*: Hospitalized from September 6 to September 26, 1963. Treated with traction, physiotherapy, and medication.
   b. When did you last examine applicant? Not answered.
6. *a. Is condition static?* Not answered.
   b. What optimum improvement can be expected? Not answered.
   c. Describe specific restrictions on patient's activity: Wears low back support; sleeps on board; further conservative therapy indicated. Lifting of heavy objects and prolonged standing prohibited.

This report did indicate that Mr. Billings had an impairment. But it did not permit a reviewing physician to determine precisely enough for disability evaluation purposes the *severity* of the impairment, the patient's work capacity *limitations,* or his *remaining capacity* to perform work-related functions. Without such information, the agency evaluation team could not determine whether to allow or deny the patient's claim. To obtain enough information to make a sound decision, they wrote to the treating physician. He promptly provided the following historical, physical, and laboratory data from his files.

New Jersey Rehabilitation Commission
Disability Determinations Service
309 Washington Street
Newark 2, New Jersey

Dear Doctor Hoerner:

In reply to your request for additional data about Mr. Charles Billings, I am able to provide the following.

Mr. Billings told me that he was in good health until he injured his back in June 1962. He complains of constant low back pain with radiation into the left leg. The pain is aggravated with prolonged standing or walking. He has difficulty in bending or stooping and tires if he drives his car more than a half hour. He denies numbness and tingling.

During the latest examination in my office, he was well developed and well nourished, and did not appear to be in any pain. He was alert, clear, and cooperative. His movements in undressing for the examination were somewhat slow; however, he experienced no difficulty. His gait was normal; he did *not* favor his left leg.

Examination of spine revealed some localized percussion tenderness over the L-4 area. There was no evidence of muscle spasm. Examination of extremities was normal with no atrophy in lower extremities. Circumferential measurement revealed the right calf and thigh to be a centimeter larger than the left. Muscle power was good in both lower extremities. The patient can stand on toes as well as heels. Romberg was negative; finger-to-nose tests were done without difficulty. Deep and superficial reflexes were symmetrically equal and physiologic: two-plus. Straight leg raising tests were negative on the right, but he complained of pain on the left at 70 degrees. Sensory system including light touch, pain, vibration, and position were entirely normal.

Radiological Findings: Recent x-ray of the lumbar spine was interpreted as follows: "the vertebral bodies are normally aligned. No degenerative changes. The interspaces are well preserved."

A myelogram done during hospitalization (September 1962) showed a small filling defect on the right side at the fourth lumbar interspace interpreted as "possible ruptured intervertebral disc."

There are no positive neurologic findings. It is possible that Mr. Billings has a herniated nucleus pulposus by myelogram: however, neurologic examination is normal. I think that conservative therapy should be continued for the low back pain and that he should restrict his activities to light physical exertion.

Sincerely yours,

Edward Parks, M.D.

Note that in his second report, Dr. Parks provided the Disability Determinations Service with concrete and helpful data. This supplementary letter was not too long nor too involved. Yet it gave what the Service needed. If the good doctor had transmitted all this in his initial report, he would have saved time and trouble for himself and expedited the disposition of his patient's case.

Remember this: in every case we need a complete and carefully dated history, detailed physical findings, and laboratory data, as well as your diagnoses and your observations on specific functional limitations. When the impairment affects the bones or organs of movement, particular data needed include the following:

1. Detailed description of clinical course and therapeutic history, with discussion of plans for further therapy, if appropriate.
2. Description of characteristics of swelling, contractures and deformities, pain, muscle atrophy, trophic changes, stiffness, and weakness.
3. General observations, including description of gait and ability to ambulate with comment on use of crutch, cane or brace, and specific description of range of motion in affected joints.
4. X-ray findings of symmetrical joints or spine selected on the basis of your history and physical examination.

If neurologic involvement is present, tell us about spontaneous and involuntary movements, clinical description of coordination and performance of skilled acts, and testing of motor and sensory systems and of the cranial nerves. Depending on the nature of neurological impairment, additional clinical data may be needed.

309 Washington Street

*Smoking and Free Fatty Acids

Cigarette smoking in humans and nicotine administration in dogs resulted in a rise in the blood of free fatty acids (FFA) in both, and an increase in urinary catecholamine excretion (norepinephrine equivalents) in humans. The FFA rise after smoking two filter-type cigarettes in a 10-minute period for patients with myocardial infarction was 65 per cent; for 10 normal subjects, 24 per cent; and 16 patients with non-coronary disorders, 27 per cent. Cathecholamine excretion levels after smoking 3 cigarettes per hour for 3 hours compared to a similar non-smoking period showed an increase, equivalent to 21 per cent, in free catecholamines and 16 per cent in total catecholamines in 11 fasting and resting subjects.

In another group in whom sympathetic ganglionic block was induced, no elevation of FFA was shown. Eight adrenalectomized patients showed only slight or no elevation of FFA in response to smoking.

The authors conclude that since smoking and nicotine change the normal pattern of some aspects of lipid metabolism, they may have etiologic significance in atherogenesis.

*Kershbaum, A.: American Medical Association Annual Meeting, June 18, 1963. Present at Research Forum there.

LETTERS TO THE JOURNAL

New Jersey Medical Schools

Dear Editor:

In a "Letter to the JOURNAL" in November, Dr. Brodkin had some interesting suggestions as to the disposition of Seton Hall Medical School, many of which are applicable and desirable. The many committee reports confuse rather than clarify the Seton Hall situation.

By all means, the state should purchase Seton Hall Medical School. It has been the only successful institution of its kind in our state and is training physicians who will potentially practice in our state. Although some students in the two-year medical school programs have difficulty finding third year seats, the small number of students in Rutgers' first classes should not present much of a problem. Ultimately Rutgers will give the state a second source of sorely needed "American trained" doctors for internships in our state. It will also give New Jersey undergraduates an opportunity to attend an in-state rather than an out-of-state medical school, which for some students is financially prohibitive.

To build a new facility in Newark would make the taxpayers' burden greater; and the last five years have proved that the Jersey City Medical Center provides an adequate training facility. The success of the five graduated classes speaks for the academic stature of Seton Hall faculty.

One feature of Dr. Brodkin's proposals is really unique. Most medical schools graduate their students with no stipulations as to where internship should be taken. Dr. Brodkin's proposal would put our medical schools in an undesirable position. This essentially prohibits students who wish to leave our state for internship from ever returning here. It interferes with the graduate's free choice of training by compelling him to take his internship in New Jersey. It restricts the students' exposure to the various schools of thought in medicine throughout the country. Those individuals who leave our state, train, and return, bring with them different and sometimes newer concepts which enhance the medical community. If the hospitals in New Jersey made their programs desirable in the teaching, working, and living conditions, the filling of these programs would be no problem.

Yes, "Let there be no more surveys or study committee program reports." Let the state buy Seton Hall Medical School, run it as a separate institution, and continue Rutgers' present program with the future of two top notch schools in our state. Also, lets not obligate the graduate to take in state internships for this may alienate under-graduate students thinking of training in our medical schools, and will discourage the out-of-state students from entering our hospitals for internships.

J. Wrable, M.D.

Jersey City

Programmed Instruction

Most exciting development in graduate education today is programmed instruction. What is it and how do you get it? To find out, take off Wednesday, April 14, and come to the Robert Treat Hotel in Newark in time for a 9:30 a.m. talk. The colloquium will run until 5:30 p.m. The hotel is across the street from Military Park, under which is a giant parking garage. This meeting is sponsored jointly by the Academy of General Practice and the State Health Department. The entire day will be devoted to methods in medical education at both undergraduate and postgraduate levels. For more details, write to Chronic Illness Control Division, State Health Department, at P. O. Box 1540, Trenton 08625.

STATE ACTIVITIES

Trustees' Minutes

November 15, 1964

A regular meeting of the Board of Trustees was held on November 15, 1964, at the Executive Offices. For the information of the membership, detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Seton Hall Report . . . Received and noted communications from the Mercer and Morris County Medical Societies supporting the report of the Seton Hall Fact Finding Committee.

Committee on Quackery . . . Appointed an *ad hoc* Committee on Quackery—to work with the AMA's committee in exchanging information and coordinating mutual efforts—as follows: Dr. Thomas DeCecio, Chairman, of Cliffside Park; Dr. John R. Gannon of Passaic; and Dr. Henry J. Mineur of Cranford.

AMA Conference on Kerr-Mills . . . Named as the Society's official representative to the conference Dr. Matthew E. Boylan of Jersey City, Chairman of MSNJ's Committee on the Chronically Ill and the Aging; and authorized the attendance of Dr. Bertram Bernstein, Director of New Jersey's MAA Program, to serve as Doctor Boylan's advisor and consultant.

National Medicolegal Symposium . . . Authorized the attendance of Robert M. Backes, Legal Counsel, and Richard I. Nevin, Executive Director, at the 1965 Symposium, jointly sponsored by the AMA and the American Bar Association.

Survey of Nursing Needs . . . Granted the request of the New Jersey State Nurses' Association to cooperate in lending assistance in its proposed survey of nursing needs, resources, and supply in New Jersey.

AMA National Educational Program . . . Directed that reply be made to the Ocean County Medical Society—in response to its dissatisfaction with the Board's action relative to the AMA's National Educational Program—as follows:

> The fourth district, in which Ocean County is located, has two elected representatives on the Board of Trustees—Dr. Albright and Dr. Hughes. The Council on Public Relations has three representatives from the fourth district. It was suggested that if the members or officers of the Ocean County Medical Society had any uncertainty about the Board's action in the matter, the fourth district representatives on the Board or council should have been contacted for a full discussion of the position taken. It was further pointed out that at the meeting of the county presidents in the Executive Offices on October 18, at which the President of the Ocean County Medical Society was present, the matter was brought up but no discussion was forthcoming. Also in the subsequent joint meeting of county presidents with the Board, no mention was made of the Society's position on the program.

Kerr-Mills Law . . . Appropriated $500 for publication of the material on the Kerr-Mills Law and Medicare in the October-November 1964 issue of the *Membership News Letter,* for distribution to MSNJ members upon request.

Referrals from 1964 House of Delegates . . . Approved the action of the Council on Legislation in disposing of items referred to it from the 1964 House of Delegates, as indicated:

1. *Resolution (#10) to make Medical Studies Confidential* (From Middlesex County) . . . urging the passage of a bill to provide that "medical studies conducted by the New Jersey Department of Public Health, MSNJ, allied health societies, and in-hospital staff committees of accredited hospitals will be of confidential character and shall be used only for medical research."

This resolution refers to a proposed bill submitted by the New Jersey Hospital Association for appreciation and criticism of MSNJ. It was referred to the Legislative Analyst, who supplied a detailed study and analysis —which was shared with the Hospital Association.

It was agreed that, since no specific legislation has yet been introduced, MSNJ could not take an official position. The council therefore directed that the resolution be received and noted.

2. *Recommendation from the Annual Report of the Committee on Mental Health* . . . urging active support by MSNJ of legislation to modernize the existing mental health laws.

It was agreed that, by taking an official position of "approval" on A-111, A-112, and A-113 (mental health bills), the council has already complied with this recommendation. The council therefore directed that the recommendation be received and filed.

3. *Resolution (#1) on Drug Addiction* (From Middlesex County) . . . to "encourage the State Legislature in demanding more stringent laws concerning the imprisonment of people involved in the illegal sale of narcotics and drugs."

It was agreed that, by taking an official position of approval on several bills introduced into the 1964 session from the New Jersey Narcotic Control Commission to accomplish this objective, the council has achieved the purpose of this section of the resolution.

The council therefore directed that the relevant section of the resolution be received and filed.

4. *Resolution (2) on Pre-Employment Physical Examinations* (From Sussex County) . . . urging MSNJ to develop and support the passage of amendments to existing law requiring the pre-employment physical examinations (on persons under 18) should be performed by either freely chosen or designated physicians.

This resolution was referred to the Legislative Analyst for study and report. He submitted a draft, embodying the directives of the resolution, which was approved by the council.

The council directed that the legislative draft be presented to the Board for its official action:

AN ACT to amend "An Act to limit and regulate child labor in this State; to provide for examinations and inspections under the provisions of this act; to provide for the enforcement of this act and regulations made thereunder; to prescribe penalties for the violation thereof; and to repeal other acts," approved June 25, 1940 (P. L. 1940, c. 153).

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. Section 8 of the act of which this act is amendatory is amended to read as follows:

8. The issuing officer shall issue such certificates only upon the application in person of the minor desiring employment, and after having approved and filed the following papers:

. . . (3) A statement of physical fitness, signed by a medical inspector employed by the applicable board of education, *or any other physician licensed to practice medicine and surgery,* setting forth that such minor has been thoroughly examined by such medical inspector, *or such other physician licensed to practice medicine and surgery,* that he either is physically fit for employment in occupations permitted for persons under eighteen years of age, or is physically fit to be employed under certain limitations, specified in the statement. If the statement of physical fitness is limited, the employment certificate issued thereon shall state clearly the limitations upon its use, and shall be valid only when used under the limitations so stated. The method of making such examinations shall be prescribed jointly by the Commissioner of Education and the State Department of Health.

5. *Resolution (#7) on Areawide Planning for Hospitals* (From Essex County) . . . urging MSNJ to participate on voluntary health facilities planning councils whose purposes are consonant with the objectives expressed in the resolution.

The council agreed that this resolution should be received and filed—for subsequent consideration, if and when such legislation is introduced.

Statewide Medical Examiners' System . . . Approved the recommendation of the Council on Legislation that a letter be sent to the Governor expressing the Society's interest and cooperation—and soliciting the Governor's assistance—of the substitution, in the protection of the public interest, of a statewide medical examiner's system for the present one of coroners and county physicians.

Current State Legislation . . . Considered the recommendations of the Council on Legislation and adopted the positions indicated:

S-348—Prohibits the taking of blood tests in drunken driving cases forcibly and against physical resistance by the defendant; requires the Commissioner of Health to determine the reliability of chemical testing devices and methods, and to adopt regulations governing their use; prescribes the implied consent

of all motor vehicle operators; prescribes hearing procedures. APPROVAL.

S-351—Establishes an adjusted personal tax rate for tangible personal property used in business within each taxing district and provides the method for the establishment of such tax rate. NO ACTION.

S-370—Provides that the taxable fair value of depreciable tangible personal property used in business shall be not less than 20% of original cost so long as same remains in use. NO ACTION.

S-385—Prohibits, as a disorderly person offense, the smelling or inhaling, or sale for such use, of glues capable of releasing toxic vapors causing intoxication, inebriation, excitement or stupefaction; exempts anesthesia for medical or dental purposes, and model kits. NO ACTION.

The council recognized the inherent danger in glue-sniffing and approved the principle embodied in the bill. However, it unanimously agreed that the danger could not be curtailed by legislation. Control should be exercised at local level. For these reasons, the council recommended a position of "no action."

A-520—Requires the testing of newborn children for the purpose of early detection of phenylketonuria; appropriates $10,000 for initiating program; effective January 1, 1965.

At its preceding meeting, the council referred this bill to the Society's Special Committee on Maternal and Infant Welfare, which had not yet made reply. The council reaffirmed its decision to defer action, pending recommendation from the Committee on Maternal and Infant Welfare.

A-692—To provide that the three full years of hospital internship required of foreign medical school graduates shall not apply to those graduates who matriculated prior to July 31, 1960 and to those who shall have begun the last 4 required years of study prior to December 31, 1960. Referred back to the Council for clarification.

A-710—Permits county prosecutors to report any physical abuses of children to any agency, public or private, authorized to perform protective services for children. APPROVAL.

A-720—Provides that the State Medical Board may refuse to grant or may suspend or revoke a license to practice medicine and surgery or chiropractic to a person who has been guilty of unprofessional, dishonorable or unethical conduct in the practice of chiropractic. DISAPPROVAL . . . because it is the conviction of MSNJ that the maintenance of professional and ethical standards is the obligation and responsibility of the professional organization in which the individual holds membership.

A-726—Reduces the age for professional nurse candidates from 20 to 18 years, increases the fees for professional and practical nursing examinations and registrations; effective July 1, 1963. APPROVAL. (This bill is identical with S-249 and A-595 of 1964, concerning which the Society's position is one of "approval".)

Electrologists . . . Directed that the Council on Legislation solicit the opinion, through the Society's official intermediary, of the New Jersey Dermatologic Society on legislation proposed to place the practice of electrolysis directly under the State Board of Medical Examiners.

Occupational Health . . . Commended Dr. Delma Caldwell for his excellent report of the AMA Congress on Occupational Health, which he attended in Texas as the Society's official representative.

Group Health Insurance . . . Met with two officers of Group Health Insurance, Inc. of New York, to explain the operation of GHI and its relationship with organized medicine in New York.

National Programs . . . Approved the following resolution for introduction by the New Jersey delegation at the 1964 AMA Clinical Convention:

> Whereas, the recent AMA National Educational Program called for action at local levels on the part of constituent associations, component societies, and individual members to provide assurances to the public that the adequacy of existing Kerr-Mills programs renders unnecessary the adoption of a federal Medicare tax program; and
>
> Whereas, such action was called for without affording those whom it involved to express their views concerning the purpose and details of the program, or without giving them the opportunity to declare whether or not they approved the program as proposed; and
>
> Whereas, in many states Kerr-Mills programs have not in fact yet developed to the point at which they can truly be said to guarantee all the care necessary for eligible beneficiaries; now therefore be it
>
> *Resolved*, that—in the interest of unity of action and of the full and energetic support of national programs of this kind by all constituent associations, component societies, and individual members —in the future, the American Medical Association afford constituent associations the opportunity of discussing and formally concurring in the proposed national programs either by vote of their delegates at AMA meetings, or by vote of authorized representatives taken at special conferences held for that purpose.

Payment of Interns and Residents . . . Authorized the introduction by the New Jersey delegation at the AMA Clinical Meeting of a resolution concerning payment of interns and residents, if such resolution seems desirable and appropriate.

AMA Delegates . . . Left to the discretion of the New Jersey delegation and officers who will attend the AMA meeting disposition of various resolutions and items from reports to be considered by the AMA House as well as nominations for the office of AMA President-Elect.

Academy of Medicine of New Jersey . . . Named Dr. Sherman Garrison of Bridgeton, Chairman of the Society's Committee on Medical Education, as the Society's representative on a committee of the Academy of Medicine of New Jersey to study continuing medical education in New Jersey.

Fiscal and Administrative Years . . . Approved the recommendations of the special committee appointed by the Board to study changing the fiscal year to identify it with the calendar year; changing the administrative year; and changing the annual meeting month and days, as follows:

1. *Annual Meeting*

After review of available sites and dates, and after a thorough discussion of the question of changing the dates of the annual meeting, the special committee recommended that no change be made from the present set up.

2. *Fiscal and Administrative Years*

The dual questions of changing the fiscal and administrative years to the calendar year were discussed thoroughly and at length. The committee concluded that the present system is superior to such changes, and that such changes would pose many problems in the transition. The committee therefore recommended that no change be made.

The committee further recommended that in future annual reports of the Committee on Finance and Budget there be included an explanation of the division of dues income necessary for budgetary purposes.

3. *Financial Reports*

The committee noted that the 1964 annual report of the Treasurer covered the 12-month period May 1, 1963, to April 30, 1964, and that the figures reported for activities in connection with THE JOURNAL and the Medical Student Loan Fund differed with the operational figures in the reports of the Committee on Publication and the Committee on Medical Student Loan Fund, both of which reported their financial activities for the periods from June 1, 1963, to March 31, 1964.

It was felt that having two sets of figures for two different periods was confusing, and the committee therefore recommended that the Committee on Publication and the Committee on Medical Student Loan Fund not include financial reports as part of their annual reports, but that the financial reports of these two committees be included as part of the Treasurer's annual report and that all cover the same period, with the same closing date.

JOURNAL . . . Approved the following recommendations of the Publication Committee, in light of the substantial increase proposed by Hibbert Printing Company in conjunction with JOURNAL publication:

1. That Hibbert Printing Company be discharged as printer of THE JOURNAL with the completion of the February issue.

2. That Printing Corporation of America be named official printer of THE JOURNAL, beginning with the March issue.

3. That subject to review and acceptance by Legal Counsel, The Medical Society of New Jersey enter into a formal written contract with Printing Corporation of America as official printer of THE JOURNAL, on a three or five year basis.

4. That the size of THE JOURNAL be changed from its original dimensions of 7-7/8" x 10-5/8" to the standard 8 x 11.

Medical Schools in New Jersey . . . Received information concerning the proposed introduction of legislation (as emergency measures) in the November 16 session of the Legislature: (1) to appropriate $6 million for the Rutgers Medical School, $1 million for the fiscal year ending in 1966; and (2) to appropriate $4 million for acquisition and $300,000 for operating costs (first 6 months of 1965) of the Seton Hall College of Medicine and Dentistry. (Both bills were passed in the Assembly and given a second reading in the Senate in November 1964. Both Houses will meet again in December.)

Hospital Utilization . . . Requested that each Trustee and the members of the Council on Medical Services complete and return a questionnaire in conjunction with the diagnosis survey undertaken by the Hospital Service Plan of New Jersey in conjunction with hospital utilization.

Retirement Plan for Physicians . . . Directed the Committee on Retirement Plant to prepare a report for publication in THE JOURNAL to encourage members to take advantage of an available retirement plan.

VA Contract . . . Assigned to the Committee on Medicare, with power, the responsibility to meet with VA representatives and attempt to negotiate a contract based on fees commensurate with the Blue Shield and Medicare fee schedules.

New Jersey Safety Council . . . Authorized a contribution of $50 for each of three years (1965-67) to the council.

December 20, 1964

A regular meeting of the Board of Trustees was held on December 20, 1964, at the Executive Offices. For your full information, detailed minutes are on file with the Secretary of your component society. A summary of the significant actions follows:

Mentally Retarded . . . Named Dr. Joseph R. Jehl of Clifton as the Society's representative to meet with the State planning committee to investigate the services offered throughout New Jersey to meet the needs of mentally retarded persons and to ascertain whether or not programs should be implemented to combat mental retardation.

National Library Week . . . Named Dr. Henry A Davidson, Editor of THE JOURNAL, as the Society's representative to serve on the New Jersey Committee for National Library Week (April 25 to May 1).

Hospital Utilization . . . Approved, at the request of Hospital Service Plan, the Schedule of Diagnosis-Based Re-Certification Intervals for adoption as a pilot study for one year, subject to the cooperation of the New Jersey Hospital Association.

Recommended to Hospital Service Plan that it use the Standard Nomenclature in the Schedule of Re-Certification Intervals instead of the International Nomenclature which currently is used.

AMA Wire Communication System . . . Approved the installation of a teletype machine in the Executive Offices, with cost of installation and rental to be paid by the AMA.

American Heart Association . . . Endorsed the "declaration of support" of the AHA, in conjunction with the Heart Association's 40th anniversary (1924-1964).

Vaccination Assistance Program . . . Agreed to cooperate with the New Jersey Health Department's campaign to encourage citizens to take advantage of all immunizations.

Physician Placement . . . Requested that THE JOURNAL publicize without charge, the names and pertinent information about physicians seeking location in New Jersey.

AMA Educational Program . . . Received the following report from the Society's representatives to the AMA sponsored meeting, held in Chicago on December 13, to discuss plans for an educational program relative to legislation:

The conference was very well attended and enthusiastically commended by both the representatives of the AMA and of the constituent associations. No definite plans for the new educational program were presented by the AMA. Group conferences—with state associations assigned to specific groups—were held. Subsequently the groups reported in a closing plenary session.

In Group II, in which New Jersey participated, the following points were stressed:

1. This should be a strictly educational program in the public interest. The PAC groups should participate only informally and as part of the general AMA membership.

2. A nationwide telecast—well advertised in advance—would probably be the best means of presenting the case against "Medicare." The arguments presented in that program could be re-emphasized at local levels in the media and by the means chosen by state societies as most desirable.

3. Preparation of informational copy—including advertisements, if they are to be used—should be under the control of the state and county societies, adapted to local conditions.

4. The AMA should supply funds and/or staff assistance to state and county societies upon request.

The AMA representatives reported that they had benefited greatly by the ideas and recommendations of the state representatives. State representatives expressed pleasure in having had the opportunity to make constructive suggestions. The general expectation was that in consequence of the planning conference the forthcoming campaign will be marked by substantial agreement and effective cooperation.

Appointed an *ad hoc* committee for the 1965 educational campaign with membership as follows:

Charles H. Calvin, M.D.
John J. Bedrick, M.D.
Joseph P. Donnelly, M.D.
John F. Kustrup, M.D.
Jesse McCall, M.D.
F. Clyde Bowers, M.D.
Richard I. Nevin

AMA Clinical Convention . . . Received the following report from Dr. Joseph P. Donnelly, Chairman of the New Jersey delegation, on the AMA 1964 Clinical Convention:

All members of the New Jersey delegation attended the sessions of the House of Delegates and took part in the deliberations of the reference committees dealing with matters of concern to The Medical Society of New Jersey and its members.

Our six delegates—Drs. Blaisdell, Donnelly, Greifinger, McCall, Mulligan, and Patterson—acknowledge with appreciation the assistance afforded them in their work by Drs. Calvin, Bedrick, Kustrup, Jehl; and Mr. Nevin—all present as official representatives of the Society. We are also indebted to Drs. Kaufman and Wegryn for the cooperation that they gave us.

Two members of the delegation had official parts in the activities of the House. Dr. Jesse McCall was a member of the Reference Committee on Legislation and Public Relations, and Dr. Isaac N. Patterson was one of the official tellers. Specific reference committee assignments were given to members of the New Jersey group, as follows:

Amendments to Constitution and Bylaws	—Dr. Bedrick
Report of the Board of Trustees	—Drs. Mulligan and Kaufman
Insurance and Medical Services	—Drs. Greifinger and Wegryn
Legislation and Public Relations	—Drs. Blaisdell, Donnelly, Patterson; and Mr. Nevin
Medical Military Affairs	—Dr. Jehl
Miscellaneous Business	—Dr. Patterson
Public Health and Occupational Health	—Dr. Calvin

The New Jersey delegation, at the direction and with the approval of the Board of Trustees, introduced but one resolution (#18) titled "National Programs." This resolution was dealt with by the Reference Committee on Legislation and Public Relations. It was lengthily discussed. Dr. Donnelly and Mr. Nevin spoke in its support.

Resolution #18

Whereas, The recent AMA National Educational Program called for action at local levels on the part of constituent associations, component societies, and individual members to provide assurances to the public that the adequacy of existing Kerr-Mills programs renders unnecessary the adoption of a federal Medicare tax program; and

Whereas, Such action was called for without affording those whom it involved to express their views concerning the purpose and details of the program, or without giving them the opportunity to declare whether or not they approved the program as proposed, and

Whereas, In many states Kerr-Mills programs have not in fact yet developed to the point at which they can truly be said to guarantee all the care necessary for eligible beneficiaries; therefore be it

Resolved, That—in the interest of unity of action and of the full and energetic support of national programs of this kind by all constituent associations, component societies, and individual members—in the future, the American Medical Association afford constituent associations the opportunity of discussing and formally concurring in proposed national programs either by vote of their delegates at AMA meetings, or by vote of authorized representatives taken at special conferences held for that purpose.

In the course of the discussion of Resolution #18 and other related resolutions, it became clear that many state associations had found it difficult to work with the national educational advertising campaign as it was originally formulated and in most instances had had to modify it according to local circumstances. It was also evident that no dependable evaluation of that campaign could be presented at this time. Results have not been statistically demonstrated—except in the election results. Out of all that was said, it became clear that the October national education campaign would have greatly benefited by more painstaking planning of a type that would take cognizance of the suggestions of the constituent associations. Planning of this type was the basic suggestion embodied in New Jersey's Resolution #18.

The Board of Trustees was apparently aware of the conclusion implicit in the remarks of speakers before the Reference Committee on Legislation and Public Relations. At any rate, the chairman of the Board of Trustees presented (under emergency rule) a special supplemental report to the House of Delegates from the Board of Trustees. The substance of that report was that, if the House approved the Board's intent to conduct a second national program within the next few months—as later the House did—a special meeting of representatives of state medical societies would be held in Chicago. The AMA undertook to pay the travel expenses of two representatives from each state to plan for the new national campaign. The report concluded: "The Board believes that the desire, expressed by several delegates at the hearing before the Reference Committee on Legislation and Public Relations, that the state societies be given an opportunity to participate in the planning of programs of this type is entirely reasonable. We hope that a meeting on December 13 will provide that opportunity."

Inasmuch as this action by the Board accomplished the recommendation contained in Resolution #18, in dealing with that resolution in its closing session the House—on the recommendation of the Reference Committee on Legislation and Public Relations—voted to take a position of "No Action" concerning the resolution. We of the New Jersey delegation felt that our resolution had fully accomplished its purpose.

In a somewhat surprising move, the Reference Committee on Reports of the Board of Trustees supported the proposal to effect the installation of a teletype communication system between AMA headquarters and all state society headquarters. The reference committee, in its report, took pains to point out that participation in the teletype communication system is optional with the state medical society. However, it recommended that each state society "seriously consider taking advantage of this rapid communications system." Dealing with the matter of cost, the reference committee emphasized the fact that the initial total cost for installing the equipment at AMA headquarters and state headquarters of all participating constituent associations would be $1,500. This amount will be paid by the AMA. Likewise the annual rental cost for the equipment at both AMA headquarters and the state association headquarters was estimated to be approximately $20,000. This cost will also be paid by the AMA. According to the reference committee's observation, the only costs that would accrue to state societies would be involved in their use of the teletype apparatus to send messages to AMA headquarters. A list of approximate cost of 900 word messages was supplied. A 900 word message from New Jersey to the AMA would cost MSNJ $3.25.

The recommendation of the reference committee was somewhat surprising because in the hearings on this subject those speaking in the name of state societies recorded themselves by a large majority as opposed to the installation. The House adopted the recommendation of the reference committee, so the project is slated to go forward.

Our delegates conferred at length with representatives of the Pennsylvania delegation, particularly with reference to the candidacy of Dr. James E. Appel of

Lancaster, Pennsylvania, who was seeking the office of president-elect of the AMA. Dr. Appel was with us at the discussion. In consequence of the impression that he made, 5 of our 6 member-delegation voted for him for president-elect and joined in the seconding of his nomination. Dr. Appel won the election. Our discussion with Pennsylvania went beyond the range of proximate concern for Dr. Appel's election, and suffice it to say that, in consequence of the discussion which took place and the attitudes that were demonstrated, we look forward to a much closer cooperation with Pennsylvania—a cooperation that may lead to the strengthening of our mutual positions in the House of Delegates.

I think I am in position to assure the Board that we have a well-knit and intensely active and loyal delegation. It is a pleasure to be privileged to work with New Jersey's representatives to the American Medical Association.

VA Contract . . . Received the following progress report from the Society's Committee on Medicare, which was assigned with power the responsibility of negotiating a contract in New Jersey based on fees commensurate with Blue Shield and medicare fee schedules:

The VA central office desires to put all contracts across the country on a relative value basis, with each state contract having its own conversion factors. The committee informed the VA representatives that the 1961 House of Delegates had rejected a Relative Value Index for New Jersey, and that any contracts must be on the "absolute fee" basis. The proposed schedule is very satisfactory and liberal as far as physician's fees are concerned. The committee anticipates receiving the final schedule for review and action early in January.

1964 Physician's Award . . . Endorsed—at the request of the Society's Committee on Rehabilitation—the submission by the New Jersey Rehabilitation Commission of the name of Dr. Sol Parent of Newark as a nominee for this year's award in conjunction with the Governor's Committee on Employment of the Handicapped.

Board of Medical Examiners . . . Approved the following nominations, in the order of preference indicated, for membership on the State Board of Medical Examiners:

Incumbent—Ralph M. L. Buchanan, M.D., Phillipsburg

Nominees:

1. Ralph M. L. Buchanan, M.D., Phillipsburg
2. Louis F. Albright, M.D., Spring Lake
3. Charles Cunningham, M.D., Vineland

Incumbent—Daniel F. Featherston, M.D., Asbury Park

Nominees:

1. Daniel F. Featherston, M.D., Asbury Park
2. John B. Fuhrmann, M.D., Flemington
3. Samuel J. Lloyd, M.D., Trenton

Bicentennial Celebration . . . Selected Saturday, October 1, 1966, for the scientific meeting to be held at Rutgers University, in conjunction with the celebration of the 200th anniversaries of MSNJ and of Rutgers University.

Medical Education for National Defense . . . Approved the following recommendations of the Committee on Disaster Medical Care in conjunction with MEND programs which are integrated into the regular courses in 88 medical schools in the United States:

1. That a letter be sent to the Dean of the new Rutgers Medical School inquiring as to whether a MEND coordinator has been appointed; if so, the committee would like to know who he is.

2. That MSNJ request of the National MEND coordinator in Washington, D. C., copies of all available information with reference to the MEND Program in the medical schools in the U. S., and that this information be kept on file in the Executive Offices.

3. That MSNJ obtain from the National League of Nursing the package curriculum and achievement test with reference to nurse preparedness for national defense; when received to be referred to the chairman of the Committee on Disaster Medical Care for summary and possible publication in a future issue of THE JOURNAL.

Influenza Vaccination . . . Approved the recommendation of the Council on Public Health that programs in support of immunization be centered in the physician's office and that recommendation for influenza vaccination be made directly by physicians to their patients without the aid of outside commercial agencies.

Congress of Parents and Teachers . . . Named Dr. John J. Bedrick of Bayonne as the official liaison representative between MSNJ and the New Jersey Congress of Parents and Teachers.

Child Safety Week . . . Approved the recommendation of the Committee on Child Health that Governor Hughes be asked to proclaim the first week in April (1965) as "Child Safety Week."

County Child Health Committees . . . Approved the recommendation of the Society's Committee on Child Health that, for better coordination, each component society be requested to supply the committee with a report of the activities of its Child (school) Health Committee each year.

Accreditation of Nursing Homes . . . Approved

the recommendation of the Committee on the Chronically Ill and the Aging that the situation concerning accreditation of nursing homes be kept under surveillance; gave as its opinion that, at the present time, there is no necessity for a physician to be a member of an inspection team of nursing homes.

Emphysema . . . Approved the recommendation of the Council on Public Health that—in addition to cancer and tuberculosis—physicians should take a more astute view of the increase in emphysema as seen in hospitals today; that any and all suggestions toward reducing emphysema be re-evaluated.

Cardiac-Surgical Centers . . . Urged the Society's representatives on the Health Facilities Planning Council of New Jersey to encourage centralization and more effective cooperative utilization of cardio-vascular surgical centers throughout the state.

MAA Program . . . Voted to urge the State Department of Institutions and Agencies to appoint a medical advisory committee to the Division of Public Welfare, to render assistance in the medical programs supervised by that Division; and in furtherance of this objective, authorized the President and Chairman of the Board to submit a list of nominees by judicial district for appointment to such a medical advisory committee.

County Welfare Board . . . Adopted the recommendation of the Committee on the Chronically Ill and the Aging that the Board of Trustees stimulate and encourage each component society to request its county freeholders to appoint a physician to membership on the county welfare board.

Mental Health Legislation . . . Adopted the recommendation of the Council on Public Health urging MSNJ to continue its support of the fundamentals previously approved in the proposed Mental Health Act.

Bergen County Resolutions . . . Received and noted three resolutions from Bergen County:

1. Urging MSNJ to support the public education programs of the AMA;

2. Suggesting that MSNJ invite the AMA Field Representative for New Jersey to all pertinent Society meetings;

3. Calling for the Bergen County Medical Society to assume responsibility in leading a comprehensive and constructive rehabilitation program with regard to chronic alcoholism.

AMA Educational Campaign . . . Received and noted communications from the Essex and Hudson County Medical Societies commending the Board of Trustees for its action concerning the AMA National Educational Campaign, which was to have been held in October 1964.

Conference on Kerr-Mills . . . Authorized Dr. Frank J. Hughes of Camden to attend the AMA Conference on Kerr-Mills (January 9-10 in Chicago), together with Dr. Matthew E. Boylan and Dr. Bertram Bernstein.

Joseph E. Mott Memorial Grant . . . Received a check in the amount of $3,600 from the Poliomyelitis Immunization Committee of the Passaic County Medical Society as a contribution to the Joseph E. Mott Memorial Grant of the Medical Student Loan Fund.

Dr. Lloyd A. Hamilton . . . Noted that Doctor Hamilton had recently been honored at a testimonial dinner in his home town celebrating his 40 years of practice; directed that a suitable resolution from the Board of Trustees be drafted and sent to him.

Rutgers Medical School

That the readers of this JOURNAL may be kept current of developments at Rutgers Medical School, we report the following major accomplishments to date:

1. From various sources, chiefly foundations and the pharmaceutical industry, we have secured gifts and commitments totalling $3,865,359 of which $2,338,876 are earmarked for construction.

2. From the State of New Jersey, by recent action of its legislature, we have received a commitment of $6,000,000 toward the construction of our building. This action received unanimous support of both chambers of the Legislature.

3. We have filed an application for a Joint Construction Grant with the Department of Health, Education and Welfare for sums totalling $8,530,968. We have also filed an application with the National Science Foundation for certain building costs.

4. Our architectural planning has progressed through the stages of programming and schematic drawings to the stage of preliminary working drawings and models of a truly handsome and highly functional building.

5. Of our professional working faculty, we have assembled eight members and are actively recruiting for the positions of chairmen of the still vacant departments.

6. The research and training activities of the staff on hand are supported by grants coming to approximately $300,000 during the current fiscal year.

7. We have developed a functional program, have agreed upon certain fundamentals of educational practice to be instituted. We now have a tentative curriculum including preliminary requirements for admission to Rutgers Medical School.

8. We have initiated agreements of affiliation with a number of hospitals in the area and expect to secure reciprocal ratification of these agreements shortly. Our clinically oriented faculty members will then be able to assume appropriate responsibilities in serving the health needs of the community.

9. We have participated as contributors and as cosponsors in numerous medical and scientific meetings designed to support the continuing education programs of the State.

10. We have successfully negotiated the first step in the accreditation process. After a site visit, the Liaison Committee on Education of the American Medical Association and the Association of American Medical Colleges has made affirmative recommendations to the Commissioner of Education of the United States. Commissioner Keppel has in turn given to the Department of Health, Education and Welfare the "reasonable assurance" of future accreditation required by the Surgeon General prior to the award of construction grants for medical education.

11. Using funds made available by the bond issue endorsed by the electorate in November 1964, supplemented by funds to be requested from the National Science Foundation, we are pressing on the planning and construction of the Library of Science and Medicine. The initial collection will include about 70,000 science volumes already on hand, some 20,000 additional medical volumes, still unprocessed, and a fine collection of 8,400 medical books recently purchased with money made available by a gift from the Commonwealth Fund.

—DeWitt Stetten, Jr., M.D.
Dean

Medical Student Loan Fund

Here is a letter recently received by Dr. Mulligan from a medical student who was helped by your Society's Loan Fund. Communications like this make us realize that this service is both useful and appreciated. It makes a real contribution to more medical care for our people.

I take this opportunity to thank you and your committee for the favorable action on my second application for a tuition loan from The Medical Society of New Jersey. Your confidence in my ability to succeed will be borne out in my future record. It is difficult to imagine how I would have been able to pay for my medical education if it had not been for generous organizations such as yours and the local, private banks. I almost gave up the idea of going to medical school until someone approached me about the possibilities of student loans. Even today, there is still a great number of well qualified, interested college graduates who cannot finance four years of medical study, and thus turn to other professions. I suppose the retort could be made to the effect that if these students really wanted medicine they would find a way of securing funds. In part, this is true. However, I would suggest that the many methods of obtaining funds to support graduate education should be made known to all medically aspiring undergraduates sometime early in their academic careers. By doing this, all interested sources of financial support will render the student an invaluable service by helping him decide at an early date, whether medical school could be included in an educational plan on the basis of academic qualification and interest alone. I believe, also, that the medical profession would have something to gain by such a program, since good men would not be turned away early in their college years because of seemingly insurmountable financial problems.

Referring specifically to the ever-increasing shortage of physicians practicing in New Jersey, I suggest that attempts be made to communicate your loan program facts to all medically oriented undergraduates who are attending New Jersey colleges. I realize that the Medical Society Loan Program could not possibly accomodate all who would apply, but at least the prospective medical student will know that someone in New Jersey is interested in helping him achieve his goal. Also, should the interested pre-medical student achieve a degree of academic excellence he would be encouraged by the fact that a New Jersey organization exists by which his ambition for medicine need not be frustrated on the basis of money alone.

I realize that the purpose of the Medical Society Loan Fund is to help reverse the tendency of native New Jersey physicians to practice in other states. Unfortunately, there is no way to guarantee that a loan will automatically convince a recipient that New Jersey is the place to set up shop. But, I can tell you from my own experience that a helping hand in a time of need is never forgotten and that your interest in me will be remembered when it comes time to go into private practice.

There are still other important reasons why the Medical Society Loan Program should be more widely publicized and implemented. One is that there is no other loan program available to New Jersey medical students which is realistic and fair towards its recipients. Although the New Jersey Higher Education Assistance Authority has pioneered a student loan program by underwriting loans made by local banks, the high interest rate of five and one-half percent (payable while one is still in school) makes this a prohibitive burden, especially when one is living on a marginal income.

I would like to conclude this long, and perhaps meandering, discussion by saying that I hope this letter in some way might help an ambitious, but not rich, pre-medical student succeed in achieving his goal.

RICHARD E. CHOJNACKI

OBITUARIES

Dr. Lee J. Hammett

An emeritus member of our Camden County Society, Dr. Lee J. Hammett, died on December 4, 1964 at the grand age of 80. A graduate of the 1912 class at the Jefferson Medical College, he was for many years the Camden City Police Surgeon. Dr. Hammett was a general practitioner of the old school, who used to say that he had probably done his best work during the real golden age of medicine. He retired a decade ago and was made an emeritus member of the County Society he had served so long and so well.

Dr. Harry Petrow Kane

President-elect of the Burlington County Medical Society, Dr. Harry Petrow Kane died on November 13, 1964 after a brief illness. Born in 1910, Dr. Kane received his M.D. at Bellevue in 1935. He interned, practiced, and did graduate work in radiology in the Bronx. In 1952 he moved to Moorestown, New Jersey, becoming attending radiologist at the Burlington County Hospital in Mount Holly. Dr. Kane was active in the affairs of his county medical society and of his adopted community in southern New Jersey.

Dr. Harold Laauwe

At the age of 62, Dr. Harold Laauwe, former Mayor of Wayne, died on December 19 of a heart attack. Dr. Laauwe was one of the most active doctors in the state in civic affairs. He was not only an ex-mayor of his native city, he was twice chairman of its Township Committee, a member of the State Fish and Game Commission, and a president of the medical staff of the Paterson General Hospital. He served in the Pacific during World War II as a medical officer in the Navy. He was an active and well-known sportsman. Dr. Laauwe was a member of the Jefferson Medical College's distinguished class of 1928. He did committee work for the Passaic County Medical Society, was elected to membership in our State's Society of Surgeons, and was a Fellow of the American Academy of Otolaryngology.

Dr. William Von Oehsen

Born in Brooklyn in 1897, William Von Oehsen enlisted in the U. S. Marine Corps at the age of 19. He served through World War I and on being mustered out in 1920, he entered Cornell University's medical school from which he received his M.D. in 1924. For a third of a century he did general practice in Bradley Beach. He had an especial interest in pediatrics and was, for many years, school physician to Neptune Township. He was on the staff of both hospitals in Long Branch and also served the Point Pleasant Hospital on the general medicine service. He opened his office in Brielle only a few weeks before his unexpected and untimely death.

Dr. Elliott C. Shull

Dr. Elliott Cogswell Shull, one of South Jersey's leading radiologists, died on December 16, 1964 while on active duty at the West Jersey Hospital in Camden, where he was director of radiology. Born in 1901, he received his M.D. at Hahnemann in 1927, and, after interneship, he entered private practice in 1928. At first he did general practice, but following graduates studies in radiology and a residency in that field, he became a Board Diplomate in Roentgenology. In 1939 he was named director of that department at the West Jersey Hospital. He also maintained an office in Cherry Hill for private practice. For 14 years, Dr. Shull was treasurer of our Camden County Medical Society. He was chief of staff at West Jersey from 1956 until last year, when he was given the unique designation of Chief, Emeritus. He was also on the Board of Trustees of that hospital.

BOOK REVIEWS

Birth Defects. Edited by Morris Fishbein, M.D. with 31 contributors. Philadelphia, 1963, Lippincott. Illustrated. Pp. 335. ($5.00)

Problems of congenital defects are closely related to population control and longevity. This book represents a forward step in integrating the rapidly expanding areas of knowledge concerned with the development of abnormalities. Any physician may be called to counsel the parents of abnormal children. To them, this text will be valuable. Too often, early diagnosis and treatment are impaired by unreasonable parental guilt feelings. Here again this book will be a useful guide.

The book covers the incidence of defects; the role of the community in research, education, and prevention; the biology of normal and abnormal cells, Mendel's Law, the desoxy ribonucleic acid molecule; alkaptonuria; phenyl ketonurisa; the impact of chemicals and physical agents on the embryo; radiosensitivity of embryonic tissue; the anatomy and physiology of the placenta; the vague frontier between normal and abnormal; and the impact on the family of abnormal offspring. All in all, this is a compact yet almost encyclopediac and unique volume. Anita Falla, M.D.

Handbook of the Practice of Anesthesia. By John R. S. Shields, M.D. St. Louis, 1963, Mosby. Pp. 203, with 113 illustrations. ($6.85)

As stated in the preface, this is essentially a "practical" book.

It presents technics of anesthesia, selection of anesthesia, changes and management during anesthesia, and monitoring devices. It is well illustrated. This volume will be useful to the experienced anesthesiologist as a guide and reference work. Victor Di Leo, M.D.

Keys to Successful Surgery. By Robert Tauber, M.D. New York, 1963, Frederick Ungar Publishing Company, Inc. Pp. 547. 209 illustrations. ($15.00)

This is the first printing of this excellent and most unusual volume by the author, who is associate professor of gynecology at the Graduate School of Medicine of the University of Pennsylvania.

The 209 illustrations begin with simple knot-tying, show several of the authors very special knot-tying technics used successfully in various locations and for very definite purposes. The volume is particularly useful in a teaching resident and intern program, since so many of its illustrations and discussions are technically basic. This is carried forward to include selected gynecologic operations with personal technics advanced by the author. Many of these depend upon special types of ligatures. The clearness of the illustrated sketches makes it particularly easy to follow each step of the operative procedure with no difficulty. Following each series of full page drawings, the whole sequence is grouped in reduced size block for quick review.

The dangers and drawbacks in some of our standard procedures are commented upon in detail and superior alternatives suggested. The particular value of the text is its simplicity in reading and its rapid reference to any of the areas covered. D. F. Featherston, M.D.

The Management of a Medical Practice. By Alan E. Nourse, M.D. and Geoffrey Marks, M.A. Philadelphia, 1963, Lippincott. Pp. 387. ($9.00)

The practical demands of medical practice presuppose a training in public relations and economics rarely received by highly trained interns and residents. Medical schools are too busy offering scientific training. The postgraduate period is preoccupied in applying such knowledge. Past medical generations in their "on the job training" were exposed to pre-

ceptors with whom young doctors not only "read medicine" but also learned its business aspects.

This book provides a wealth of material usually divulged by the old successful family doctor. The volume deals with basic technics in patient management; locating in practice; office management; estate planning, personal finances, insurance; and in an analysis of a successful practice. The volume would make an ideal gift from hospital medical staffs to its graduating interns and residents.

William Furst, M.D.

Physiology of the Circulation in Human Limbs in Health and Disease. By John T. Shepherd, M.D. Philadelphia, 1963, Saunders. Pp. 416. 179 illustrations. ($12.00)

In the preface to this book, Professor Shepherd says that he wrote this text for four groups of people: "the graduate student with a major interest in the cardiovascular system; the young investigator anxious to survey the general field to be better able to decide on fruitful areas for study; the experienced investigator looking for a source book; the clinician whose interest is in diseases affecting the vascular system and who wishes to have a basic textbook on the behavior of human blood vessel in health and disease."

For physiologists and other scientific investigators it is, indeed, an excellent source book with 179 vivid illustrations and a wealth of references. But for the clinician, interested in vascular or cardiovascular diseases, this volume leaves much to be desired. The format of the first three sections (which are highly scientific and technical in nature, and rather difficult in reading and interpretation) is continued in the fourth and clinical sections.

A proper summary or resume of the findings and their clinical interpretations at the end of each chapter in this section would make this excellent scientific tome more palatable and valuable to the medical practitioner.

Jacob Schmukler, M.D.

The Prospect of Immortality. By Robert C. Ettinger, Garden City, N. Y., 1964. Doubleday and Company. Pp. 190. No index. ($3.95).

If, shortly after death, a body could be frozen at (or near) absolute zero, it would remain indefinitely without deterioration. Eventually, medical science will reach a point where the disease that killed the person could be cured. By that time, it should also be easy to thaw out frozen tissue. Then the person could be revived, and the diseased organ replaced. Thus, he would start a new life better than new. It would even be more desirable, Mr. Ettinger suggests, to freeze people just before dying. It would be easier to thaw a person out of suspended animation than to revive him after death. Mr. Ettinger considers such problems as how to finance the freezers, where to stack the bodies, how religious people would react, and even the delicate legal question of whether bodies parked in freezer for rejuvenation could be considered dead for the purpose of life insurance. If a person had only $1000 in his estate when he died, and if he were revived in 300 years, this small sum would, by 3 per cent compound interest, have grown to $7,000,000. Thus, as Mr. Ettinger suggests, under this plan, you *can* take it with you. The book is written with grace and wit. The subject, though treated earnestly (I am sure Mr. Ettinger is really serious about his proposal), is handled without any macabre overtones. If you shudder at the idea of being in a deep freeze for three centuries, you would have to admit, says the author, that the freezer is more attractive than the grave. Mr. Ettinger is described as a teacher of physics. No other identifying information is given. There are no pictures.

Joseph Hochstadt, M.D.

Intestinal Biopsy. Edited by G. E. W. Wolstenholme, M. A. and Margaret P. Cameron, M. A. Boston, 1963, Little, Brown and Company. Pp. 120. 53 illustrations. ($2.95)

This small and inexpensive volume summarizes information obtained by the relatively recent technic of intestinal biopsy in cases of malabsorption syndrome, especially the gluten-

induced type of steatorrhea. The tissues obtained have been variously examined using the dissecting microscope, light microscope, electron microscope, and histochemical studies, with varying degrees of correlated *in vivo* functional studies.

These papers illustrate the inadequacy of our present knowledge of the basic anatomy, pathology, and physiology of the small bowel. In addition, the limited experience and relatively small groups of patients available to individual observers are partly responsible for much of the divergence of opinion. Our knowledge will be enlarged by these sorts of investigations stimulated by biopsy technic.

In contrast to some of the previous Ciba Symposia, this volume is oriented chiefly towards *clinical* research, and will be of most interest to the gastroenterologist, internist, pathologist or others concerned with diseases of the small intestine. The feeling of uncertainty and lack of agreement between all of the investigators are more than compensated for by the exciting and up-to-date findings provided by prompt publication of these preliminary studies. The included discussion of each paper is also stimulating and highlights the areas of disagreement or lack of information.

Jacques B. Wallach, M.D.

Electrocardiography. By Michael Bernreiter, M.D. Ed. 2. Philadelphia, 1963, Lippincott. Pp. 202. ($7.50)

This reviewer is frequently asked by students, interns, or practitioners, to recommend a good elementary text on electrocardiography. Bernreiter's *Electrocardiography* is the ideal answer.

This small book sets out to instruct in the fundamentals of electrocardiography and in the basic abnormalities encountered in everyday practice. In simple, lucid language, it accomplishes its mission. It is a textbook, not a source book. It is not a reference work for the rarely encountered bizarre or problem electrocardiogram. This is no book from which to learn about parasystole, reentry, or vector analysis. On the contrary, by adhering to the common and ordinary electrocardiographic phenomena and by utilizing a brief and explicit text, the author makes himself easily understood. He begins with basic tenets, describes them succinctly, and then goes on to apply the same language in describing the many illustrative graphs. There are more than 150 of these, each obviously well chosen. The beginner can learn a great deal from this book and without too much effort. It might better be titled "A Primer of Electrocardiography." Harvey Nussbaum, M.D.

Medical Department, U. S. Army: Organization and Administration in World War II. Washington, D. C., 1963. Department of the Army. Edited by Colonel J. B. Coates, MC and C. M. Wiltse, Ph.D. Pp. 613. 123 illustrations.

To most of us, the infuriating aspect of war service was entanglement in bureaucratic red tape. At least, so it seemed at the time. Looking back at it through the nostalgic haze of two decades, we are not so sure. The Medical Corps really did a terrific and unprecedented job in record time. This book is a smoothly written, very human account of the administrative headaches associated with that operation. Here you will find a candid story of that war within the war: the efforts (generally successful) of the Army Air Corps medical department to divorce itself from the rest of the Army.

This volume has a disarming frankness unexpected in official publications. We are told how the U. S. Public Health Service criticized the Army Medical Corps for the way it implemented the May Act (control of prostitution near Army installations) and how Army medical officers fumed as a result of the criticism. The Wadhams Committee investigation is interpreted as "an implied distrust of the Medical Department's effectiveness." The book says that General Marshall became impatient of prophecies by the SGO; and that he "was determinedly opposed to the reappointment of The Surgeon General." We are given a behind-the-scenes story of how General Kirk was selected as The Surgeon General in 1943. The Chief of Staff

and the Secretary of War had first named General Kenner, but "as a concession to the insistence of the civilian medical profession, a candidate more acceptable to the profession was named."

The placement of the medical department under Supply was a constant pebble in the department's shoe. Even The Surgeon General had no direct access to the Secretary of War. (Admiral McIntyre could get the Secretary of the Navy any time.) This unwillingness to give the senior surgeon a top staff post haunted Army medicine throughout the war. The Surgeon General's failure to get the personnel he needed was (in the opinion of two named supply officers) "attributed to General Magee's medical education." (Apparently the theory was that a medical education robs you of aggressiveness!)

The subordination of medical to supply services gave the Air Surgeon a little ammunition. "Under the Army's theory," he suggested, "medical officers are pooled and dealt out like so many trucks from warehouses." They contrasted this with the tender rapport between airmen and *their* medical officers.

The text includes a theatre-by-theatre account of medical administrative problems during the war. Medical officers in Australia, says the editor, "needed a talent for diplomacy, improvisation, and adjustment: skills not mentioned in Army manuals." As one who was there, this reviewer can only say "amen."

I suppose that the detailed description of administrative channels will not enchant all readers; though to natural bureaucrats like the undersigned, it makes interesting reading. In a remarkable *tour de force* the authors have taken what ought to be a dry and dull recital and turned it into a dramatic story of human interpersonal conflict.

We never thought so at the time, but most of us converted civilians who served then and there have to admit that, when the chips were down, the Army knew what it was doing.

Henry A. Davidson, M.D.

Pediatric Cardiology. By Alexander S. Nadas, M.D. 2nd Edition. Philadelphia, 1963, Saunders. Pp. 828. Illustrated. ($16.00)

The second edition of this book is magnificent. Obviously essential to anyone in the field, it will be just as useful to any doctor who sees children with heart disease.

The author manages to present intricate and complicated situations in such a simple way that as a ready reference for the office this book is superb. In the same vein he describes all the tools of diagnosis available to the largest centers and still presents the problem as evaluated by the average M.D.

There are easily comprehended picturizations of the heart, blood flow, pressures, etc., shown for many conditions. Accompanying EKG's illustrate the findings. There are photographs here and there of certain cases where the whole aspect of the child is helpful.

A collection of charts in the back make this even more useful as an office reference.

Certainly every pediatrician will want one of these. Phoebe Hudson, M.D.

Cancer of the Female Reproductive Organs. By Alfred I. Sherman, M.D. St. Louis, 1963, Mosby. Pp. 338. Illustrated. ($13.75)

The subject of cancer related to the female reproductive organs has been individually explored and recorded before. It has nowhere been assimilated for more convenient study than in this text. Dr. Sherman has encompassed all clinical aspects of gynecologic oncology from diagnosis to management of persistent carcinoma in a clearcut manner easy to digest.

Two chapters—"Use of radiation in the treatment of cancers of the female reproductive organs" and "Survival statistics"— are masterful monographs in themselves.

This reviewer would have appreciated specific case history presentations, particularly where complications and failures were concerned. But this is a minor fault. I would characterize this as an excellent text and a "must" reading for the practicing gynecologist.

Robert V. Dorian, M.D.

Obstetrics and Gynecology. By J. R. Willson, M.D.; C. T. Beecham, M.D.; and E. R. Carrington, M.D. Ed. 2. St. Louis, 1963, Mosby. Pp. 735 with 333 illustrations. ($13.75)

In this textbook, the authors offer under a single cover the combined fields of obstetrics and gynecology. The volume was specifically designed for medical students. The succinct paragraphs, clear print, and bold sub-titles allow for easy reading. This format gives the book the flavor of an "outline" with minimal explanations of the textual data. The section on oxytocic injections is, in this reviewer's opinion, quite inadequate. The book lacks any discussion of hemolytic disease of the newborn. The historical and scientific background for current concepts is absent. There is very little in the text to encourage the student toward further study or additional reading. This book cannot, in my opinion, serve as a desirable foundation for students of obstetrics and gynecology.

Aaron Shinbein, M.D.

A Review of Medical Physiology. By William F. Ganong, M.D. Los Altos, California, 1963, Lange Medical Publications. Pp. 577. Softcover, lithographed. ($6.50)

In this compact and (for these times) relatively inexpensive volume, the basic principles of human (actually mammalian) physiology are outlined, with many examples from clinical medicine. Dr. Ganong buys the compactness at the price of not listing all the investigators; and not providing a detailed discussion of the experimental background of the conclusions. For most clinicians this is a good compromise. Many usable tables are found in the text and in the back of the book. The volume is produced by lithography, and the resulting monotony of type-faces will bother some readers. Illustrations are highly diagrammatic, but their clarity is probably enhanced by this fact. The text covers the physiology of metabolism, nervous system activity, excretion, respiration, circulation, muscle activity, and other related physiologic processes. In all this is a handy and readable review for the student and reference work for the practitioner.

Ulysses M. Frank, M.D.

Physical Diagnosis. By John A. Prior, M.D. and Jack Silberstein, M.D. 2nd Edition. St. Louis, 1963, Mosby. Pp. 455. 277 illustrations. ($8.50)

Laboratory tests and the advancing front of automation have led to a kind of push-button diagnostic technic in modern medicine. Medical students are particularly likely to fall under the spell of complex laboratory tests. This book is addressed to the medical student and, indeed, opens with the phrase "as a medical student, you are the physician of tomorrow and need to understand that the doctor is a medical detective."

Prior and Silberstein give us a compact handbook on how to take a history and do a physical examination. The text opens with a practical 30-page treatise on how to take a medical history—fast becoming a lost art. A usable chapter on how to do a mental examination then follows. Thereafter, each body system is treated in order. All in all this is a veritable refresher course—in the best meaning of the word "refresher"—in how to make a diagnosis.

Felix A. Ucko, M.D.

Results of Surgery for Peptic Ulcer. Edited by R. W. Postlethwait. M.D. Philadelphia, 1963, Saunders. Pp. 308 ($8.00)

This represents a cooperative study at 12 Veteran Administration Hospitals. The work is valuable not only for the data, but also for the diversity in surgical treatment that characterizes the report. It covers more than 13,000 admissions for duodenal and 2,500 for gastric ulcers; the number of operations was 2,977, approximately 20 per cent.

There is no unanimity among the surgeons as to *when* operation is indicated for peptic ulcer, nor as to *what* operation is best. Perforation is considered an indication for surgery although a few surgeons recommend non-operative treatment. Operation is simple closure. More often, of late, resection is the procedure of choice since a large proportion are said to have subsequent difficulty.

There are no common criteria for surgical

intervention during hemorrhage. Advocates of both late and early surgery say their pieces. At least two procedures are popular: (1) gastric resection with excision of the ulcer and (2) vagotomy and pyloroplasty with transfixation suture of the ulcer. There is least agreement on obstruction as an indication for surgery.

The most important surgical indication for gastric ulcer is the failure to differentiate benign from malignant disease. Results of surgery in duodenal patients with intractability were not as good as in those patients in whom surgery was done for other causes. There is an increasing tendency to perform vagotomy with antrectomy or vagotomy with 50 per cent resection because of decreased mortality, morbidity, and postoperative incidence of marginal ulcer.

A. I. Friedman, M.D.

Evaluation of Thyroid and Parathyroid Functions. Edited by F. William Sunderman, M.D. and F. William Sunderman, Jr., M.D. Philadelphia, 1963, Lippincott. Pp. 292. ($12.50)

This is an edited collection of papers presented at a seminar of the Association of Clinical Scientists. It deals with detailed laboratory methods, interpretation of findings and, to some degree, their correlation with clinical observations. The first section of the book is devoted to the history, anatomy and histology, laboratory methods for the study of thyroid function, thyroiditis, hyperthyroidism, and malignant diseases of the thyroid.

The second part covers histology and pathology of the parathyroid glands, bio-assay and chemistry of the parathyroid hormone, and many laboratory procedures for determination of calcium and phosphorus in serum, urine, and feces. One of the papers has an impressive list of 196 references. Both sections are concluded with excellent presentations of clinical diagnosis, differential diagnosis, and therapy.

Since this volume contains a number of diagnostic procedures not currently found in textbooks of clinical pathology, it will serve as a fine reference for the clinical investigator, pathologist, biochemist, and laboratory worker.

George M. Cohn, M.D.

Handbook of Ocular Therapeutics. By P. P. Ellis, M.D. and D. L. Smith, Ph.D., M.D St. Louis, 1963, Mosby, Pp. 193. ($8.50)

This handbook is indeed a handy book to have within easy reach. True, the material contains nothing that the well-read ophthalmologist does not already know. Instead of the material being scattered about in various journals, however, it is all within a pair of book covers, all in one place, well-written and clearly presented.

The opinions and methods of authorities are freely utilized and, for the sake of brevity, discussion and controversy are necessarily limited. One cannot take issue with that. The material is refreshingly up-to-date, 5-iodo-2'deoxyruridine being well presented. The division into principles and practices of therapy and a discussion of the therapeutic agents is logical and helpful.

In summary, this handbook serves as a good, reliable reference for therapy and pharmacology and is a valuable addition to the bookshelf nearest the desk.

S. Jerome Greenfield, M.D.

Crossen's Synopsis of Gynecology. By Daniel W. Beacham, M.D. and W. D. Beacham, M.D. 6th Edition. St. Louis, 1963, Mosby. Pp. 371. 106 illustrations. ($7.50)

It is now 30 years since *Crossen's Synopsis of Gynecology* was first published. It has been revised, reedited, and in parts rewritten several times (1937, 1946, 1956, 1959, 1963)—and this is accolade enough. Obviously, this compact *Synopsis* has filled a need. It is pocket-sized, has a flexible binding, is well illustrated, and can be carried conveniently or kept in a desk drawer or doctor's bag. It gives the basic facts about the commoner gynecologic disorders in straightforward fashion—etiology, symptoms, diagnosis, management. An extremely valuable chapter on gynecologic diagnosis and examination is a feature of this as of previous editions, and includes a useful set of common errors and how to avoid them. It is one of the best short volumes on gynecology available to the general practitioner.

Victor Huberman, M.D.

Modern Clinical Psychiatry. Ed. 6. By A. P. Noyes, M.D. and Lawrence C. Kolb, M.D. Philadelphia, 1963, Saunders. Pp. 586. ($8.00)

Since 1934, this has been a standard medical student's textbook of psychiatry. Its frequent reprinting says all that need be said about the usefulness of this work. The current edition includes new thoughts on the psychosomatic aspects of genito-urinary disorders. Material on mental deficiency has been updated, and the chapter on drug therapies has been rewritten. A compact and practical section on group therapy has been included. The dynamic orientation of the earlier editions has been preserved. A good chapter on the history of psychiatry opens the text. Especially valuable—and practical—is the long chapter on how to examine a patient. The book well deserves the accolade given to it by thirty years of medical school classes. Abraham Leff, M.D.

Books Received

The Blood Program in World War II. Government Printing Office, 1964, Washington, D. C. Pp. 922. Illustrated. ($8.00). Army experiences in its blood procurement and utilization program between 1941 and 1953.

Polypoid Lesions of the Gastrointestinal Tract. By Claud E. Welch, M.D. Philadelphia, 1964, W. B. Saunders Company. Pp. 148, illustrated. ($7.50). A pocket manual on the regulation and management of polypoid lesions of the lower bowel.

The Mask of Sanity. By Hervey Cleckley, M.D. Fourth Edition. St. Louis, 1964, Mosby. Pp. 510. ($9.75). Since 1941, the best available clarification of the antisocial or psychopathic personality.

Medicine and Health in New Jersey: A History. By David L. Cowen, M.A., Princeton, 1964. Pp. 227 with 12 illustrations. ($3.95). Volume 16 of our State's tercentenary historical series. From the health of the colony in 1680 to the reintroduced Mental Health Act of 1964.

The Retinal Vessels. By R. Seitz, M.D. Translated from the German by F. C. Blodi, M.D. St. Louis, 1964, Mosby. Pp. 186. ($14.50). A profusely illustrated review of ophthalmoscopic, histologic, and text studies of the blood vessels of the normal and diseased eye.

Disaster Handbook. By S. Garb, M.D. and E. Eng, R.N. New York, 1964, Springer. Pp. 248. (Flexible cover at $3.50; hardback at $4.75). A practical handbook for physicians, nurses, and others who have to take leadership in disasters running the alphabetical gamut from avalanches, airplane crashes, and earthquakes all the way to tornadoes, wrecks, and volcanic eruptions.

The Law and Mental Disorder. Committee on Legislation of the Canadian Mental Health Association. Toronto, 1964, Canada. Pp. 36. (Paperback $1.25). A compact summary of Canadian laws covering the examination and hospitalization of mental patients, including problems in evaluating competency.

Opportunities in a Psychiatric Career. By Henry A. Davidson, M.D., New York, 1964, Universal Publishing Corporation (Vocational Guidance Manuals). Pp. 144. (Softback $1.45; hardback $2.75). A compact, practical guide to training and practice opportunities for the budding psychiatrist.

Industrial and Traumatic Ophthalmology. The Transactions of the 1963 session of the New Orleans Academy of Ophthalmology. St. Louis, 1964, Mosby. Pp. 321 with 134 illustrations. ($14.50). A review of ophthalmologic problems in industry, automobile driving, and direct injury—including technics of disability evaluation.

Current Practices in Orthopedic Surgery. Edited by John P. Adams, M.D. St. Louis, 1964, Mosby. Pp. 231 with 126 illustrations. ($13.50). A practical review of current orthopedical practices.

Rehabilitation Medicine. By Howard A. Rusk, M.D. and 36 collaborators. St. Louis, 1964, Mosby. Second Edition. Pp. 668 with 210 illustrations. ($15.50). A second edition of this now classic book on rehabilitation and physical medicine.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

FEBRUARY, 1965 • VOL. XXXVIII, NO. 2

Reactivation of Inactive Pulmonary Tuberculosis

In a study conducted among former tuberculosis patients whose names were on the registry of a local health department, 8 per cent were found to have reactivated. Long-term medical supervision of inactive cases, with bacteriologic studies, is recommended.

The reactivation of apparently inactive pulmonary tuberculosis has drawn increasing attention from both clinicians and those in public health. Most studies of reactivated disease have been among Veterans Administration hospital patients or patients discharged from sanatoriums. The present study was conducted among patients whose names were on the tuberculosis registry of a local health department.

The study had several objectives. They were (a) to determine the number of reactivated cases among persons with apparently inactive pulmonary tuberculosis; (b) to obtain data, for both the reactivated and inactive groups, on sex, age, extent of disease, and type and duration of treatment; (c) to compare the extent of disease in the reactivated group with diagnosis at the time of reactivation; (d) to establish and maintain a register of inactive cases of pulmonary tuberculosis; and (e) to determine an effective method of following inactive cases to prevent reactivation.

Records were reviewed of persons with a diagnosis of active pulmonary tuberculosis known to the Long Beach Health Department from 1935 to 1960. Of these, 2,536 were selected because the disease had become inactive, and 1,508 were invited to participate in the study because of availability of addresses.

Former patients living in the Long Beach metropolitan area were asked to visit the health department for a chest X-ray and bacteriologic studies. If they preferred, they could request these examinations of their private physicians.

Procedure Followed

Those residing outside the Long Beach area were asked to visit their physician or local health department. Results were to be forwarded to the Long Beach Health Department. The health department of jurisdiction and hospitals and other health agencies were informed of the project.

Of the 399 responses, 343 persons visited the Long Beach Health Department, and 28 others, under the care of a private physician, gave the health department permission to obtain the desired information from the physician. Information concerning another 28 was received from such sources as hospitals and health departments. Only 16 refused to participate in the study.

History was obtained for each person who visited the health department for the interval between prior treatment and the beginning of the study. In addition, a 14- x 17-inch chest X-ray film was taken and a specimen for bacteriologic study was requested.

Bacteriologic studies were extended over a two-month period to allow time for adequate cultures. All studies included a niacin test to exclude unclassified mycobacteria. A health department physician reviewed the test results

I. D. Litwack, M.D., and John Gardner, M.D.
Public Health Reports, September, 1964.

and completed the study history form. The latest chest X-ray was compared with earlier films available in the patient's records.

A summary of findings was sent to the patient's private physician, and the patient was notified by mail of the test results. Persons with positive chest X-rays or bacteriologic findings indicating active disease were urged to obtain medical care.

Reactivated Disease

Evaluations were completed on 383 persons, or 15 per cent of the 2,536 selected for the study. Thirty-one persons, or 8.09 per cent, were found to have reactivated disease. The status of 352 persons remained inactive.

Moderately advanced tuberculosis had been the most frequent diagnosis in both the inactive and reactivated groups: 58 per cent of those with reactivated disease and 42 per cent of the inactive group. In the reactivated group about 23 per cent had minimal disease, and 19 per cent, far advanced; among those with inactive disease, 41 per cent had a diagnosis of minimal disease, and 16 per cent, far advanced.

Men outnumbered women in both groups, comprising 55 per cent of the reactivated group and 60 per cent of those with inactive tuberculosis. Most of the 383 persons in the study were in the 35 to 64-age category, forming 71 per cent of the reactivated group and 74 per cent of the inactive group. In the reactivated group, only 2 were under 35 and 7 were 65 or older. In the inactive group, 8 per cent were under 35 and 18 per cent were 65 or older.

A smaller percentage of the persons with reactivated disease had received drug treatment (35.5 per cent) and had undergone one or more surgical operation (22.6 per cent) than those in the inactive group, of whom 42.6 per cent had taken drugs and 29.5 per cent had been treated surgically.

Of those with reactivated disease, 6 had had tuberculosis drugs for two years or more, 5 for less than two years, and 20 had received no drugs. In the larger inactive group, 58 had received chemotherapy for more than two years, 92 for less than two years, and 202 had had none.

When previous X-ray films of the 31 patients with reactivated disease were compared with those taken during the study, 22, or 71 per cent, showed no evidence of change; 9 revealed a new infiltrate. Chest X-rays of those in the inactive group showed no change in disease status.

Diagnosis of 10 patients with reactivated tuberculosis changed from that recorded at the time of inactivation. Improvement in the disease status was noted in 5.

Cases of reactivated pulmonary tuberculosis undoubtedly exist among those who did not respond to letters inviting participation in the study and among those for whom no current address could be obtained. The records of 635 deceased persons will be followed to determine if active pulmonary tuberculosis was a cause of death.

Based on results of the study, the following recommendations are made concerning cases of inactive pulmonary tuberculosis:

1. Annual medical supervision is needed for years, possibly for life.

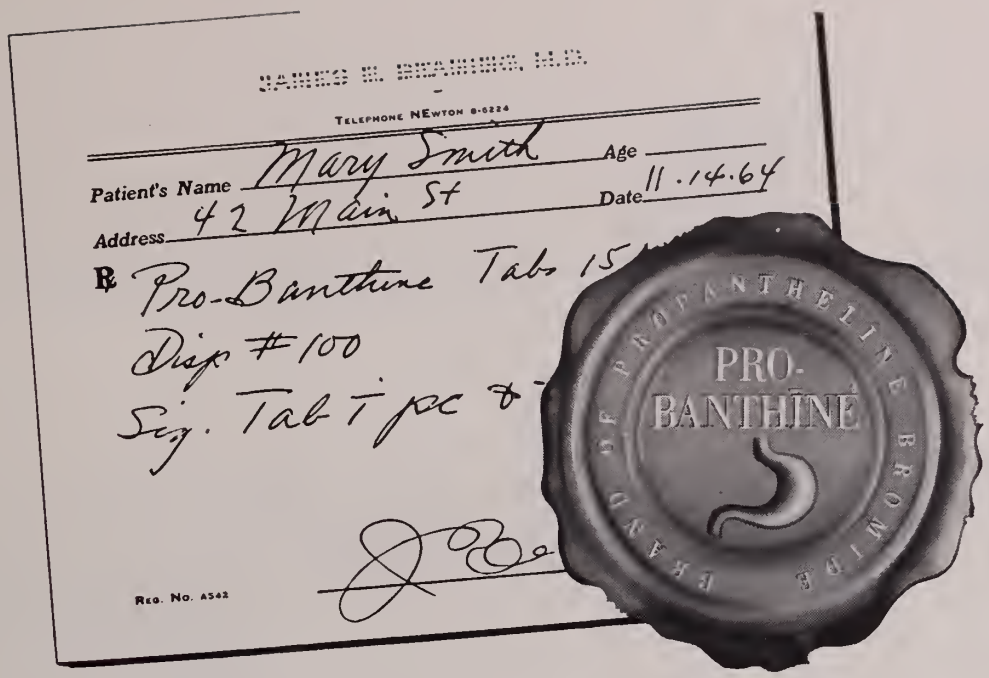
2. Bacteriologic studies should be included, as well as comparison of chest X-ray films with earlier films.

3. All patients who have not received adequate chemotherapy should be on a prophylactic medical regimen for two years.

4. An orientation program for both physician and patient should be undertaken.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
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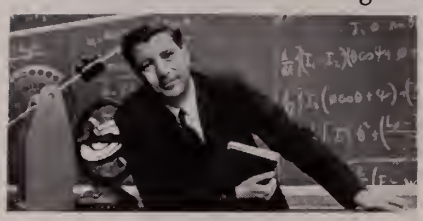
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1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press *243*:578 (June 29) 1960.

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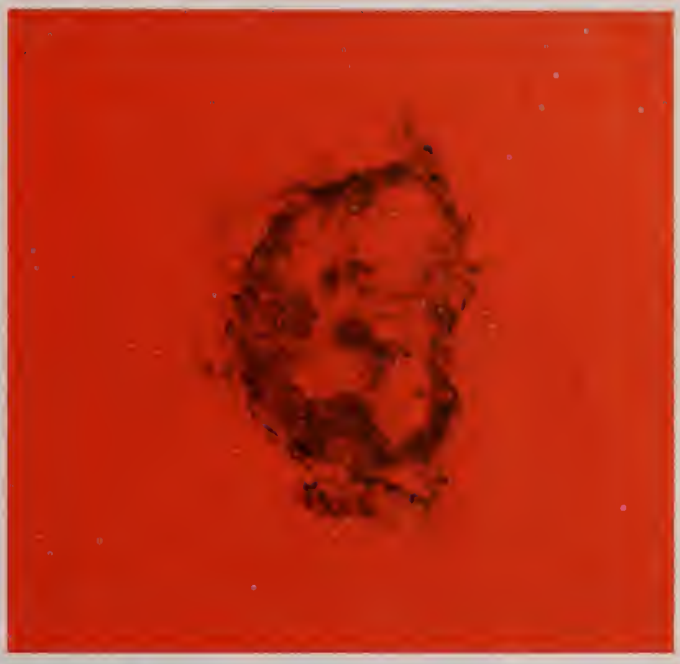
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[1]Foret, J.: Antibiot. Ann. 1958-195

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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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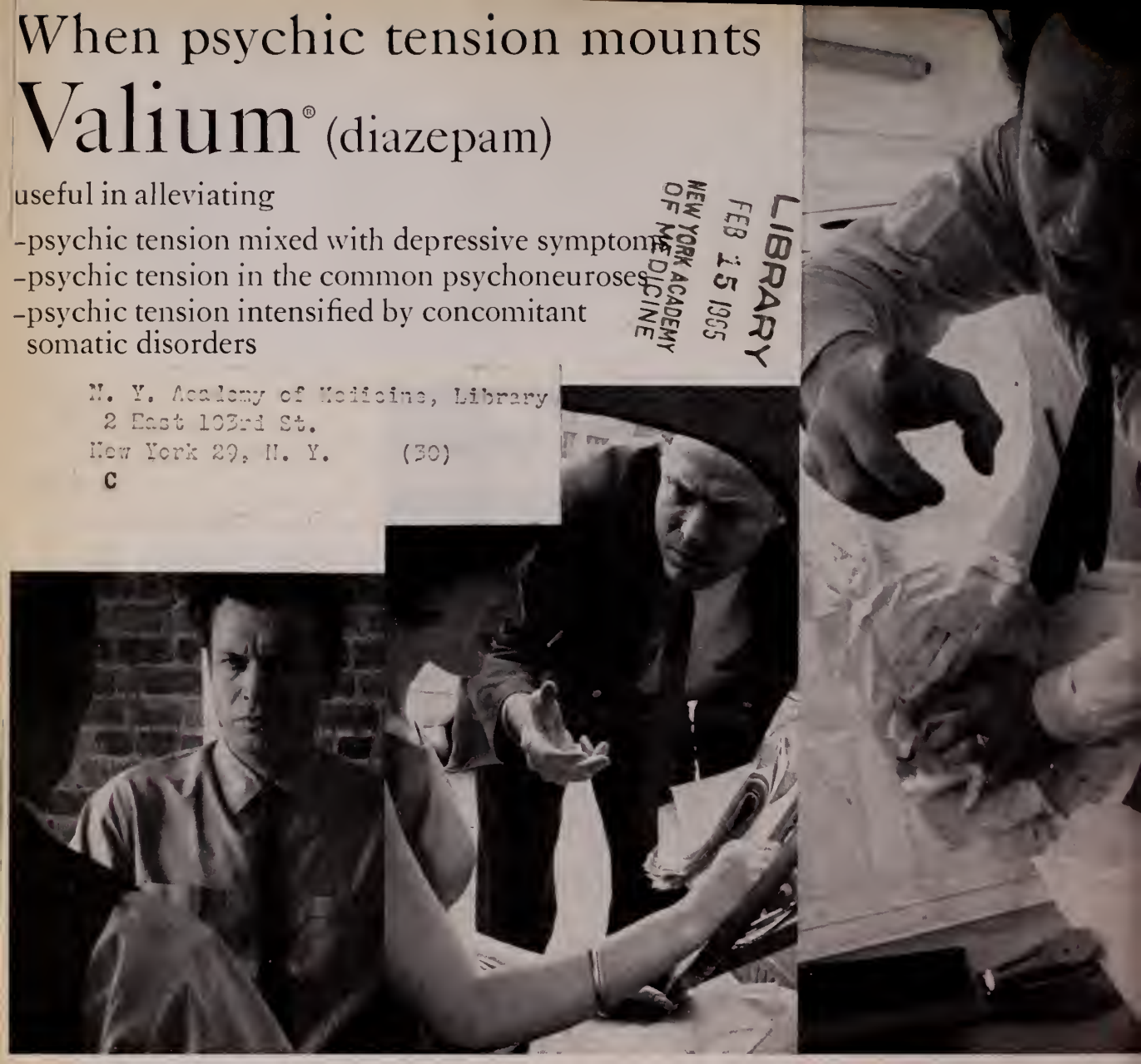
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How to prescribe Valium (diazepam)

Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue.

Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal.

Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in the treatment of psychotic patients, and for this reason should not be employed in lieu of appropriate treatment.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (e.g., convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

Valium (diazepam) is available as 5-mg and 2-mg tablets. For convenience and economy in prescribing, both strengths are supplied in bottles of 50.

Roche Laboratories endorses the principle of caution in the administration of any therapeutic agent to pregnant patients.

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THE JOURNAL
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MARCH, 1965 Vol. 62, No. 3

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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone reserpine in moderately severe and severe h tension: A two year study. Presented at the Inter-American Congress of Cardiology, Mo June 14–19, 1964.

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1. Clinical report on file, Medical Department, A. H. Robins Co., Inc.
2. Schiller, I. W. and Lowell, F. C.: New England J. Med. 261:478, 1959.

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REFERENCES: 1. Epstein, J. H.: Am. J. of Gastroent., 37:295, March, 1962. 2. Breidenbach, W. C.: Investigative Clinical Report, March, 1961. 3. Young, R., and Sun, D. C. H.: Ann. N. Y. Acad. Sc., 99:174, Feb., 1962. 4 Slanger, A.: Journal of New Drugs, 2:215, July-Aug., 1962. 5. Posey, E. L., Jr.: Am. J. Dig. Dis., 7:863, Oct., 1962.

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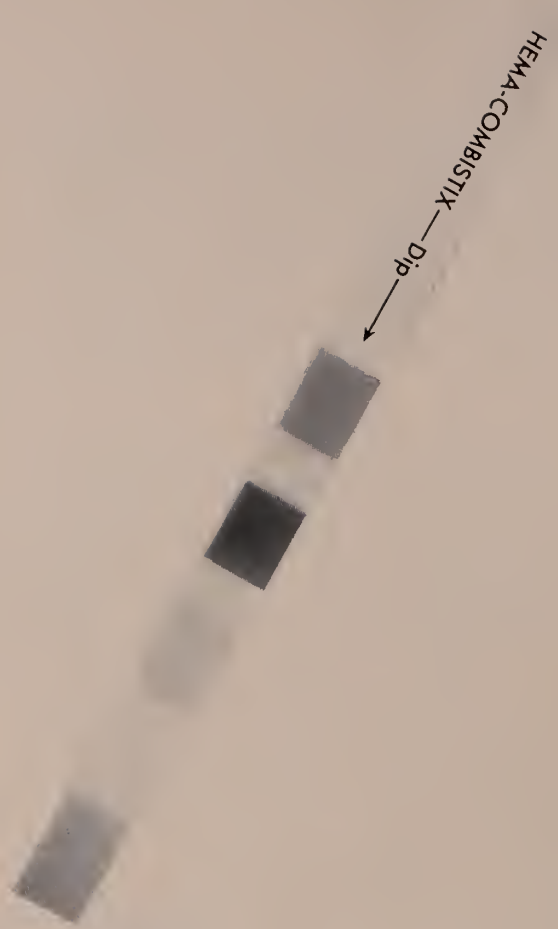
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References: 1. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 2. Editorial. Lancet *ii*:723 (Oct. 5) 1963. 3. Parker, M. T., *et al.*: Brit. M. J. *i*:1550, 1962. 4. Evans, W., and Hansman, D.: Lancet *i*:451 (Feb. 23) 1963. 5. Richards, J. D. M., and Rycroft, J. A.: Lancet *i*:553 (March 9) 1963. 6. Schaedler, R. W., *et al.*: New England J. Med. *270*:127 (Jan. 16) 1964. 7. Howard, P., and Riley, H. D., Jr.: Abstracts, Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, Oct. 26-28, 1964, New York, N.Y.

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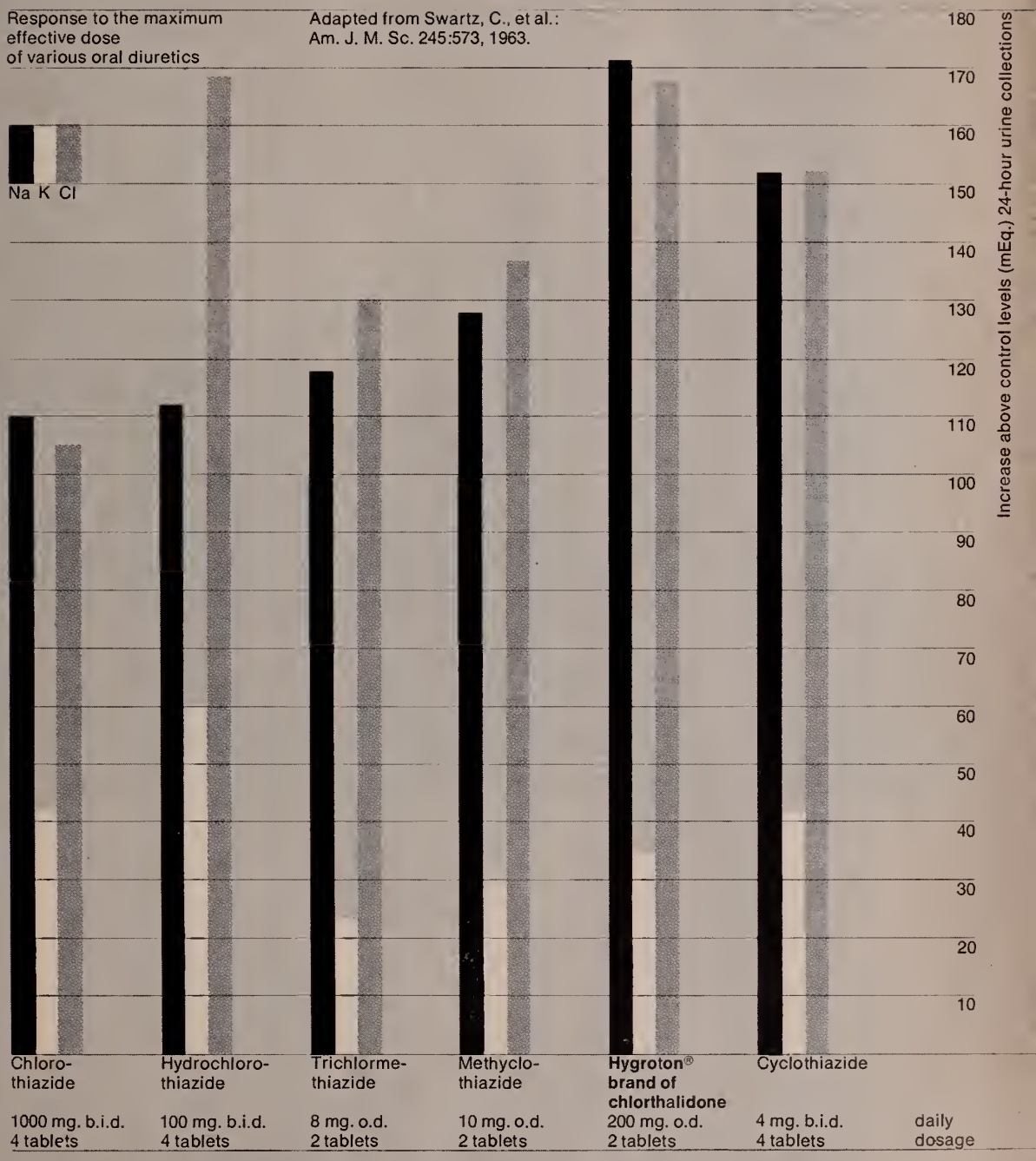
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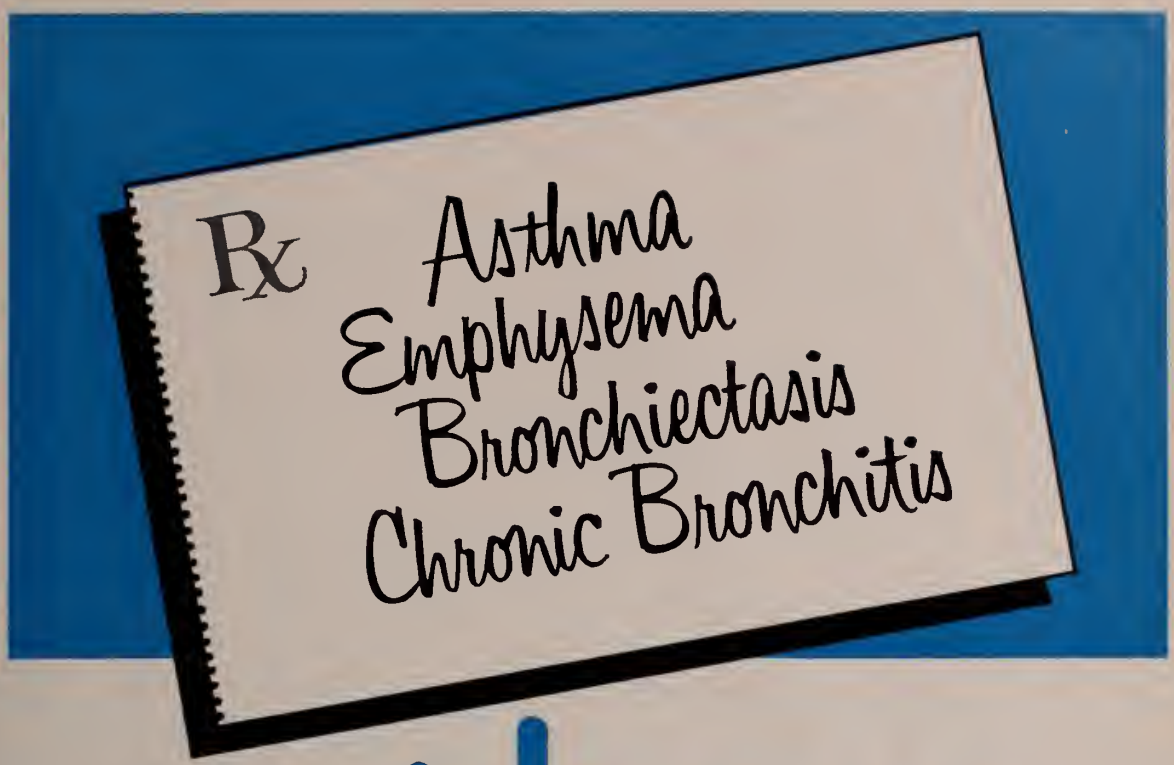
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1. Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. 2. Weller, C. et al.: Scientific Exhibit, A.M.A., June, 1962. 3 Moss, J. M. et al.: Medical Times 92:645, 1964.

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*A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963.

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1. Griffith, R.S., and Black, H.R.: Current Ther. Res., 6: 253, 1964.

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EDITORIALS

The Journal Moves Forward

Again, we make changes in THE JOURNAL. With this issue the size has been changed slightly to conform with the average size of state medical journals. And other changes are in the making. Our new printer, the Periodical Press, has extensive facilities which will help us greatly in the production of a better journal and in the battle with ever-increasing costs.

Since your Publication Committee is constantly striving to improve THE JOURNAL, we are pleased with the response to the recent postcard survey that so many of you took the trouble to complete and return. In our endeavors to make THE JOURNAL as useful as possible to our members, we are always grateful for comments, criticisms, and suggestions from you. We give them careful deliberation. So, please do not hesitate to write us whenever you have something to say.

George B. Sharbaugh, M.D.
Chairman
Publication Committee

Medical Responsibility For The Alcoholic

Doctors don't like to treat drunks. They call at inconvenient hours. They are hard to handle, often threatening, obscene, dirty, noisy, vomiting, and ungrateful. One gets the feeling that if alcoholism *is* a disease, it is a self-induced one. Alcoholics are unsatisfactory long-term patients, too. They don't follow the physician's advice. They show a marked tendency to relapse. And most of us are too busy to drain out all the time and energy which these patients demand. The alcoholic is also the subject of jesting and contempt. So our lack of interest is understandable.

But, for all that, we insist that alcoholism *is* a disease. Some experimenters have, indeed, in the name of science, taken enormous quantities of alcohol with the expectation of making alcoholics out of themselves. All they did was to disgust themselves with drinking and convert themselves into tee-totallers. Thus, one apparently needs some kind of diathesis to became an alcoholic: which puts it in the "disease" category. Not only that, but the alcoholic is desperately in need of help; and as physicians, we are expected to be long on compassion. Here in New Jersey, we see some alcohol-control clinics set up under the aegis of teachers, non-medical public health officers, social workers, and psychologists. If we protest, we are reminded that very few M.D.'s are willing to work in such installations.

But we can't have it both ways. If we insist that alcoholism is a disease, we have a duty to take leadership in combatting it. We welcome the recent resolution* of our Bergen County Medical Society, calling on physicians "to assume responsibility in leading a comprehensive rehabilitation program" in this field.

Merely a Practitioner

Your big-eared reporter was eaves-dropping in the staff room. The professor was planning a program on "recent advances in internal medicine." The curriculum was designed for general practitioners and family doctors. The problem at the moment was selecting the faculty. Your reporter heard one name suggested: that of a competent, respected, busy, and—be it known—beloved internist in the community. The professor demurred. "After all," he said, "he is merely a practitioner."

The implication was clear. This good doctor, it seems, was not suitable as a teacher, because his experience was "merely" in the practice of medicine, not in research or pedagogy. He knew people, but he couldn't compute an index of correlation. He could make a diagnosis, but he was not fluent in applying the Henderson-Hasselbach equation** to theoretical problems in respiratory physiology. He had successfully treated many sick people, but he had never done a single

* See page 112 this JOURNAL.

** We can't either, but we can give you a good reference—Editor.

research project. He enjoyed the professional respect of dozens of shrewd practitioners, but his list of papers written was embarrassingly short. The interns, residents, and junior staff doctors on his service found him a gold-mine of practical advice, keen observation, and sound clinical judgment; but he didn't have a single faculty appointment.

He was merely a practitioner. So was Walter Reed. And Semmelweiss. And Sigmund Freud. And Thomas Addison. And Billroth and Banting, and Richard Bright. Not to mention Harvey, Halsted, and Hunter. Robert Koch was a country doctor and Joseph Lister a general hospital surgeon. And so the list rolls on.

Practitioners, all of them. Mere practitioners!

Research By Medical Students

Elsewhere in this issue* is a paper on catecholamine deprivation, written by a medical student at Seton Hall. This is a product of an almost unique research-opportunity program offered to students at that school. Although Seton Hall College of Medicine recognizes that its primary aim is to train doctors to treat sick people, it also knows that there will be no progress in medicine unless some doctors devote time, effort, and thought to basic and clinical research. Seton Hall's summer research fellowship project started in 1957 (only a year after the first class was admitted). Since that time some 300 medical and dental students have had an opportunity to engage in summer research under nearly optimum conditions.

Participation is voluntary. Through contacts with faculty members, students become aware of the research projects under way in the College. Any student who wants to participate in research is encouraged to do so under the sponsorship of a faculty member. The sponsor and student together plan the activity and submit a blue-print to a Fellowship Committee for approval. This insures a meaningful research experience for the student rather than just a summer spent as a technical assistant. Modest stipends ($300 a month) are paid to Summer Fellows out of grants from the National Institutes of Health, private and public health agencies, and industry.

Under the guidance of faculty sponsors, Summer Research Fellows learn the technics needed for a successful attack on limited research problems. Then they proceed to the experimental problem itself. Some projects require a team approach. In that case, the Summer Fellow becomes a member of the team and assumes certain responsibilities for the prosecution of the project.

Summer Fellows are encouraged to analyze and write up their results in good scientific fashion. They get a chance to present the reports at regularly occurring symposia.

Research topics are broad in coverage extending from such areas as the analysis of metabolite transport across cell membranes to the development of a technic for the detection and interpretation of heart sounds for clinical diagnosis. Sometimes a student's interest (and perhaps unbridled inquisitiveness) leads to really important basic discoveries. This was the case this past summer when a student working on chromosomal aberrations in disease states overturned a popular notion held by cytogeneticists solely because he questioned the majority opinion.

The objective of the Summer Research Fellowship program is to encourage students *to try research*. Some will find it most exciting and some will not react with enthusiasm. If the Summer Fellow should find he has a special talent worth exploiting we have gained a medical researcher and an academic person. If not, he will be a better physician for having been exposed to the method and discipline of the research laboratory.

We hear a lot these days on the question of whether a medical school should aim to train biologic scientists or medical practitioners. As Seton Hall here shows, a medical school can do both.

* See page 94 this issue.

ORIGINAL ARTICLES

The site of America's first medical society will be perpetuated by a marker in New Brunswick.

The Oldest in the Nation

Fred B. Rogers, M.D./Trenton

The Medical Society of New Jersey, which will celebrate its bicentennial next year, was founded on July 23, 1766, at Mr. Duff's Tavern in New Brunswick. Meeting in response to advertisement in the public press, seventeen New Jersey physicians formed an organization "for their mutual improvement, the advancement of the profession and the public good." (The Tercentenary Edition of *The New Jersey Almanac* (1964, p. 213) recently cited this event.) First lasting provincial medical society in British North America, the lofty ideals of this premier body continue to motivate the medical profession.

In its marking program the Historic Sites Evaluation Committee of the New Jersey Department of Conservation and Economic Development has installed a commemorative marker at the site of Duff's Inn in New Brunswick. This location, at the northeast corner of Albany and Peace Streets, near the Raritan River Bridge, is now occupied by an office of the New Jersey Bell Telephone Company. This Company, appreciating our State heritage, has publicized history in print through its *Tel-News* and *New Jersey Bell.*

Ever since 1752, a tavern or inn occupied the site in New Brunswick now marked by the Medical Society plaque. Known as the White Hart Tavern before it was purchased by Michael Duff, Governor William Franklin* of New Jersey was entertained there in 1763. The Reverend Robert McKean of Perth Amboy, first president of The Medical Society of New Jersey, presided at that body's organizational meeting in 1766. His successor, Dr. William Burnet of Newark, led subsequent sessions convened at Mr. Duff's in 1768 and 1769. The



MEDICAL SOCIETY

THE MEDICAL SOCIETY OF NEW JERSEY - OLDEST STATE MEDICAL ORGANIZATION IN THE NATION - WAS FOUNDED HERE, AT DUFF'S INN, IN 1766.

third president, Dr. John Cochran ("Doctor Bones") of New Brunswick, chaired meetings there from 1770 to 1775.

This hostelry served other notable guests during the colonial and Revolutionary periods. Generals George Washington, Charles Lee, and Philip Schuyler were accomodated there in 1775. The Provincial Congress of New Jersey met at Duff's daily during the month of February 1776. Benjamin Franklin, John Adams, and Edward Rutledge visited it in 1778. Alexander Hamilton, Lord Stirling, and the Marquis de Lafayette also lodged there during the War for Independence. After the war, the Grand Lodge of Masons of New Jersey was formed in 1786, and President John Adams was feted there in 1797. W. H. S. Demarest chronicled the parade of history through this hotel historic in his account, *The Anniversary of New Brunswick, New Jersey, 1680-1730-1930* (New Brunswick, N.J., 1932, p. 66).

* Son of Benjamin Franklin.

By the year 1936, when Dr. Frank Overton, then editor of the JOURNAL, photographed what had been Duff's Tavern, the two upper stories were removed from the old structure and its first-floor was being used as a luncheonette. His photograph and one showing the intact building in the 1870's were reproduced in the JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY (September 1936) 33: 543. Later, due to further ravages of time, the venerable landmark was demolished and replaced by the present modern facility.

The State of New Jersey, by marking the site of Mr. Duff's Tavern in New Brunswick, has heralded the coming bicentennial observances of the founding in that place of The Medical Society of New Jersey and of Rutgers University. The Rutgers Medical School, which plans to admit its first class in 1966, will share in next year's pageantry. The medical profession of New Jersey, proud of its pioneer tradition, looks forward to future opportunities in education and service.

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	Double (Twin Beds) side ocean view	For Two Persons	$19.00 ( ) $21.00 ( ) $23.00 ( )	$16.00 ( ) $19.00 ( )
	Double (Twin Beds) ocean front	For Two Persons	$27.00 ( ) $30.00 ( )	$19.00 ( ) $21.00 ( ) $23.00 ( )
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This reservation will be acknowledged. Please arrange to double up when possible—single rooms are limited.
NOTE: As check-out hour is 3:00 p.m., rooms may not be ready earlier.

An infusion of ThioTEPA® during mastectomy may be helpful in controlling breast cancer.

Adjuvant Chemotherapy During Operation For Breast Cancer:*

A Preliminary Report

Lester A. Barnett, M.D./Long Branch

In 1891 Halsted[1] described the classical radical mastectomy for primary breast cancer. Today more confusion exists about the management of this common malignancy than ever before. Many reports suggest that radical mastectomy is no longer a standardized procedure. Some of the controversial challenges worthy of consideration are: (1) radiation therapy alone;[2] (2) preoperative radiation therapy;[3] (3) conservative mastectomy;[4,5] (4) extended radical mastectomy;[6 to 8] (5) simple mastectomy with radiation therapy;[10] and simple mastectomy with delayed axillary dissection.[11] Haagensen[12] has long advocated rigid criteria of operability by his selective "triple biopsy" technic. And many current reports deal with adjuvant prophylactic measures, such as oopherectomy[13] and chemotherapy.[14]

In 1961, the presentation of the Surgical Adjuvant Chemotherapy Breast Group of the Cancer Chemotherapy National Service Center before the American Surgical Association[14] was the first significant evaluation of adjuvant chemotherapy presented to the physicians of this country. This presented preliminary data on a nation-wide cooperative study of the use of thioTEPA® (triethylenethiophosphoramide) as adjuvant to curative radical mastectomy for cancer of the breast. After an initial 24-month study, "the data accumulated indicated a statistically significant decrease in the early recurrence rate among patients who received thioTEPA as adjuvant to operation in comparison with the control group who received only radical mastectomy." It has recently been reported[15] that the beneficial effect is particularly seen in the premenopausal woman with axillary metastases (Stage II), with recurrences developing later as well as less frequently than in the control group.

In May 1961, we began to use adjuvant chemotherapy with thioTEPA® in three daily doses following radical mastectomy. Three months later we added a thioTEPA intravenous infusion during the operative procedure, the data and results of which are the basis of this preliminary report.

Materials and Methods

The initial study of 108 patients by the Surgical Adjuvant Chemotherapy Breast Group utilized a dose of 0.8 milligrams per kilogram of body weight of thioTEPA,® 0.4 milligram given the day of operation and 0.2 on the first and 0.2 on the second postoperative day. Subsequently, the Breast Group reduced the dosage on the following 610 patients to 0.6 milligrams per kilogram of body weight, 0.2 milligrams on the day of operation and 0.2 on the first and another 0.2 on the second

* From the Department of Surgery at the Monmouth Medical Center in Long Branch, where the author is Director of the Department.

postoperative day. While it appeared that the higher dose was more effective (and that complications were relatively the same throughout both portions of the test, treated and control groups), the lower dosage was used because of a high incidence of complications noted in other adjuvant chemotherapy studies. Almost a third of all the patients, treated and control groups, showed some type of complication—local, systemic, or combined—indicating individual susceptibility to thioTEPA.®

We initially used a fixed dose for every patient regardless of body weight, giving 15 milligrams of thioTEPA® in 20 cubic centimeters of distilled water intravenously on the day of operation and on the first and second postoperative days, a total of 45 milligrams of chemotherapeutic agent. In eleven patients so treated, only three developed mild complications, two with small areas of wound edge necrosis and one with anemia.

In August 1961, we instituted the "thioTEPA® drip" consisting of 15 milligrams of thioTEPA® in 500 cubic centimeters of dextrose in water started intravenously in the operating room before the biopsy incision is made, on all patients suspected of a malignant lesion. Where a doubt exists, the drip is initiated and is then discontinued if the frozen section is reported as "benign." When the frozen section is reported as "malignant," the drip is continued throughout the entire operation (radical mastectomy) and the flow rate adjusted to finish shortly after the final skin suture is placed. Fifteen milligrams of thioTEPA® in 20 cubic centimeters of distilled water is then given intravenously in the usual manner for three additional days following operation. Again, without regard for body weight, a total dose of 60 milligrams of thioTEPA® was thus administered to each mastectomy patient over a four-day period. The patients' weights ranged from 50 to 82 kilograms so that the calculated dosages ranged from 1.2 to 0.7 milligrams per kilo of body weight. It is readily seen that some patients received twice the dose of the Breast Group patients; none received as little as the 0.6 milligram per kilo dose standardized by the Breast Group. None of our twenty patients treated by the "thioTEPA drip®" developed complications sufficiently severe to require reduction of the dosage.

All the wounds were inspected at intervals of the third, sixth, and eighth postoperative days to record any local complications such as tissue necrosis, graft death, or dehiscence. Blood counts, including platelet studies, were taken on the day following operation and once or twice again prior to discharge on the tenth postoperative day to detect any hematologic complications.

Results

Twenty patients with primary breast cancer were treated by radical mastectomy and adjuvant chemotherapy with thioTEPA,® by the method described, over a period of three years. The patients ranged from 28 to 70 years of age, and 50 kilograms (110 pounds) to 82 kilograms (180 pounds) of body weight. Eighteen tumors were duct cell carcinomas and two were lobular carcinomas.

Clinically, 17 patients were evaluated as Stage I. Three were considered as Stage II. Operatively, 12 patients proved to be Stage I, and seven were in Stage II. One patient, found to have microscopic metastases of lobular carcinoma to the appendix removed during prophylactic oopherectomy, was graded as Stage IV. Radiation therapy was given to all patients in Stage II and to those Stage I patients with medially placed lesions.

There have been no deaths in this small series to date. Nineteen patients are clinically free of disease, including the aforementioned 44-year-old patient with distant (appendiceal) metastases present at the time of initial treatment eighteen months ago. The twentieth patient is a 36 year old woman found to have extensive involvement of the axillary glands at mastectomy and who received postoperative radiation therapy. Supraclavicular spread became evident seven months later, and she received additional radiation therapy to this area plus radiation castration of a remaining

ovary. She is now well, twenty months post-mastectomy.

There have been few complications in spite of the rather large dose (60 milligrams) of thioTEPA® administered to each patient regardless of body weight or age. There were 10 instances of incisional necrosis, none requiring additional procedures; 5 were minimal and 5 required routine debridement, healing well shortly thereafter. Two patients developed fever for two days, both fevers being of pulmonary origin. Three patients required transfusions prior to discharge for low blood counts felt to be due to systemic chemotherapy effect. More difficult to evaluate was a feeling of malaise experienced by half the patients during the first few postoperative days while receiving daily thioTEPA.®

None of these local and systemic complications were alarming and none required termination of proposed dosage. When evaluated with previous patients not receiving chemotherapy, there seemed little if any difference except for the malaise during the period of administration of the chemotherapeutic agent.

Comments

Reports[16] have shown that viable malignant cells are found in the circulating blood stream in most, if not all, cases of breast cancer. Studies[17] in laboratory animals have demonstrated that growth of cancer cells injected into the blood stream can be significantly decreased by the additional injection of several chemotherapeutic compounds. The use of thioTEPA® in conjunction with operation to prevent implantation and growth of circulating cancer cells in distant organ areas is the basis for the study by the Surgical Adjuvant Chemotherapy Breast Group.

While previous investigators utilized chemotherapeutic agents "at the time of operation," the actual injections were made immediately after operation.[18] To us, it seemed important to add an "infusion" of chemotherapeutic agent *during* the operative manipulations of biopsy and mastectomy, to act upon the cancer cells being released before implantation, and thereby significantly reduce blood stream dissemination. This in addition to three daily doses of thioTEPA on following days, as it has been demonstrated[17] in the laboratory that the chemotherapeutic curability of solid tumors in experimental animals is greatest soon after implantation and is inversely proportional to the amount of tumor tissue present.

While the patients in our study received a higher dose of thioTEPA® than those in the Surgical Adjuvant Chemotherapy Breast Group study (up to twice the total dose), the complication rate was no higher than reported by that group and apparently somewhat less. Certainly, the local and systemic complications have not posed a problem for us to date.

Patients in this series were not treated any differently from our previous patients who act as our "control group," but received radiation therapy and oopherectomy postoperatively where indicated as heretofore. Although no deaths have occurred at this writing, the length of this study is too brief for proper evaluation.

The purpose of this preliminary report is to direct attention to the technic of *intraoperative* chemotherapeutic infusion and its effectiveness in reducing the circulating malignant cells released during operative manipulation. We hope to encourage others to join in investigating its potentialities. Perhaps a different dose schedule would prove more effective by concentrating a larger dose into the operative period (30 milligrams) and only one dose of 15 milligrams of thioTEPA® the day following operation. While we have not concerned ourselves with body weight, a milligram per kilo dosage schedule would be statistically more accurate for evaluation of the drug effect. Other types of operable malignant solid tumors could be treated by this method. Certainly, other investigators with larger series of cases will be needed before any significant data can be presented. We must also await the

results of five and ten year follow-up studies in our group of patients.

Summary

Chemotherapy with thioTEPA® (triethylenethiophosphoramide) as an adjunct to radical mastectomy for the treatment of cancer of the breast has shown a statistically significant decrease in the recurrence rate, recurrences developing later and less frequently than in control groups. A total of 0.6 milligrams per kilo of body weight is the standard dose distributed as 0.2 milligrams per kilo on the day of operation and on the first and second postoperative days (Surgical Adjuvant Chemotherapy Breast Group).

We have employed a "thioTEPA drip"® of 15 milligrams of thioTEPA® in 500 cubic centimeters of dextrose in water as an operative infusion started prior to breast biopsy and terminated at the conclusion of the radical mastectomy. Additional doses of 15 milligrams in 20 cubic centimeters of distilled water are given intravenously for three additional days for a total dose of 60 milligrams of thioTEPA.® Systemic blood stream dissemination of malignant cells during the operative manipulations of biopsy and mastectomy may be considerably reduced by the simultaneous infusion of chemotherapeutic agent, thereby further reducing the incidence of recurrences.

Twenty patients over a three-year period have been thus treated and carefully followed. Local and systemic complications have been mild and infrequent, comparing favorably with the control group of radical mastectomy patients not receiving adjuvant chemotherapy. Malaise during the administration of chemotherapeutic agent and anemia 7 to 10 days postoperatively were occassional complications not affecting the treatment program.

There have been no deaths in this series to date, although one patient demonstrated metastatic disease in a prophylactically removed appendix at the time of initial treatment and a second patient developed spread of disease to the homolateral supraclavicular area. This study is too small and the time interval too short for significant evaluation but is presented for possible further investigation by others interested in this problem. It is suggested that varying combinations of dosage, technics and chemotherapeutic agents used to treat malignant solid tumors of the breast and other organs during the operative period may yield important results.

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255 Third Avenue

Hermaphroditism is rare enough to warrant a case report—especially one with a happy outcome.

A Case of Pseudohermaphroditism

With A Note As To The Psychiatrist's Role

J. Chernus, M.D./East Orange

Wilkins,[1] Hampson,[2] Money,[3] Moore,[4] and Rosenwald,[5] have written extensively on the diagnosis and treatment of hermaphroditism and pseudohermaphroditism. They have cited groups of patients from 5 to 60 in number. However, the condition is sufficiently rare and challenging to warrant the report of a single case, especially from the viewpoint of what the psychiatrist can contribute to its management. In the reports of the authors cited, there is uniform agreement on two points:

(1) The personal orientation of the patient so afflicted is consistent with the *assigned* sex (the way he is reared in the family) and is *not* at all influenced by chromosomal, hormonal, or gonadal factors. (This finding coincides with psychoanalytic findings in most homosexuals, in whom sexual attitudes are the reverse of their biological endowment.)

(2) If the *assigned* sex does not correspond with the biologic sex, surgical reversal, where feasible, should not be undertaken if the child is beyond infancy. Moore[4] puts it at 18 to 24 months. Rosenwald,[5] citing one of his group of five as undergoing reversal successfully at age 4½, attributes this success to "special circumstances;" and citing Wilkins' findings,[1] warns that reversal "is seldom advisable where the child is beyond infancy, but should be considered."

None of his four patients, who were reared as girls, seemed to mind the loss of the phallus-like clitoris. This is offered as evidence against the psychoanalytic concept of "penis-envy." Though seemingly a logical observation, it is our opinion that the finding does not necessarily disprove this concept of "penis envy," since his patients, by his own evaluation, were free of significant psychopathology, and were between the ages of 4½ and 6, when the "penis-envy" phase of libidinal development has waxed and waned, and been replaced by a feminine orientation. The central constellation of this is passively to receive the paternal phallus, as a way of fulfilling the genital wish (to have a baby, as the penis equivalent and "replacement"). Since the orientation by this time is passive-receptive genitality, it is not surprising that they did not mind losing the clitoris; in fact, they were probably glad to get rid of this despised antithesis to feminine orientation.

The findings in our case support the literature cited as to the all importance of *assigned* sex versus biologic factors. However, on the second point [the age beyond which reversal usually may not be considered], our findings suggest that there may perhaps be a little wider latitude. We agree with Hampson[2] that, in reversal of gender, the parental feelings and attitudes are all important for successful outcome.

REPORT OF A CASE

Albert was brought by his parents to the Plastic Surgery Clinic of the St. Barnabas Medical Center in October 1960. He was then

two years, three months old. Albert was the second pregnancy. A brother, 14 months older, was living, well, and genitally normal. During the first trimester of this pregnancy, there was the threat of miscarriage, and the mother had "to take some pills" for about two weeks, after which the pregnancy continued uneventfully. Albert was delivered spontaneously at term. The mother was informed that she had given birth to a girl, and the child was appropriately named Catherine and registered as a female.

However, the external genitalia were not normally female; there was a phallus-like organ and an apparent absence of labia (or scrotum). The doctor told the mother that the phallus-like organ was a tumor, which would have to be removed when the baby was older.

Three weeks after birth, the doctor informed the mother that her child was, indeed, a boy, whose penis was not entirely normal and who had no scrotum, or a rudimentary one. The birth certificate was accordingly changed legally, and the child's name was changed to Albert. The child remained under the care of a urologist, as a boy. However, the mother had vague uneasiness and uncertainty as to the true sex. Accordingly, she brought him to the clinic in October 1960. He was a healthy looking boy, with a general body build not inconsistent with the assigned sex. The external genitalia were abnormal: a phallus with what appeared to be a typical hypospadias; below this a wrinkled and rough area, without the presence of obvious scrotum, testes, or labia.

The first procedure was a biopsy of skin and cartilage from the left ear, for sex chromatin determination. A 17 ketosteroid determination showed 1 mg per 24 hours, and pregnanediol .03 mg per 24 hours. At laparotomy, on October 26, 1960, a normal uterus, left tube, and ovary were found. On the right side, only a round ligament was present. Biopsy of the left ovary showed healthy ovarian tissue. Further lipiodol study showed a vaginal cavity that communicated with an unusually long cervix, normal uterus, and left tube.

Now comes the essential question: whether, at the age of 2½, to reverse the assigned sex to correspond with the biologic sex; or whether to ablate the female organs and hormonally virilize the child to help maintain the assigned sex *status quo*. It was at this point that consultation was requested of the psychiatric staff, to help arrive at a decision.

Our first examination revealed an apparent male child, moderately unhappy in the hospital setting. He appeared to be of average intelligence, and there were no mannerisms or behavior patterns or gestural patterns suggesting psychopathology. Speech was adequately developed, but verbal content had not gone beyond naming and demanding to afford any clues as to identification processes. The mother was not sure whether he habitually stood or sat when urinating. She had never seen him fondling the genitalia. He had never ventured any questions or expressional interest in his genitals, or their difference from mother. He had not expressed any interest in the older brother's or father's genitals. Beyond average play activity, he had shown no apparent strong male identification thus far.

At staff conference, I offered the psychiatric opinion that the child was sufficiently "undifferentiated" still to undertake surgical concordance with biologic sex. There being no medical or surgical contraindications (and with the parents' full understanding and consent), a corrective operation was performed on November 21, 1960. A herniorrhaphy-like procedure removed the contents of the right inguinal canal; and a clitoridectomy was performed at the same time. The pathologic report was that the biopsy specimen from the left ovary was normal ovarian tissue. The tissue from the right inguinal canal microscopically showed both primitive ovarian and testicular cells; also rudimentary epidydimis, vas deferens and corpus cavernosum. Microscopically, then, it was a case of arrested true hermaphroditism.

Post-operative course was normal, and no adverse psychologic reaction could be detected in the immediate post-operative weeks. The

child was re-named Alberta, and legally re-registered as a female.

Follow-up examinations were conducted at annual intervals, the last one when she was 5 years, 4 months of age. In the first follow up examination (age 3 years, 4 months) Alberta showed normal intellectual and "ego" development. Speech, motility, independent activities were normal for her age. Toilet training had been completed about six months earlier. She was able to separate from her mother and enter into a happy, trustful play activity with us. In her play, she showed a decided preference for guns, trucks, etc., and rejected dolls, and toy furniture. At the same time, the mother's attitude toward Alberta's new sexual identity seemed confused, uncertain, and regretful. The mother complained that urination was difficult for Alberta in typical female manner.

We satisfied ourselves on this point by inviting the child into the bathroom, where she unhesitatingly sat and urinated without any discomfort, or displeasure. She smiled, somewhat owlishly, both in urinating and in the play with guns, as if searching for our approval. We concluded that any apparent male orientation was part of the normal "penis envy" stage, and also a reaction to the mother's ambivalence.

On the next annual visit, age 4 years, 4 months, physical, intellectual, and psychologic growth were observed to be normal. The interpersonal dynamic balance between the parents was in a high state of flux at this time. The father had lost his job and moved the family to another town in search of a new and more productive career. The mother was less ambivalent toward Alberta, and was undergoing some lively interaction with her own mother. She seemed more accepting of, and reconciled to, Alberta's feminine status. There was no complaint about urinating or masturbating; she expressed more optimism that things would go well for Alberta in the future.

Psychologic examination (at age 4 years, 8 months) showed normal intelligence (I.Q. 103). Projective tests showed some tendency to impulsivity, along with low frustration tolerance and some preoccupation with "fire," "hell," and "bad." There appeared to be a slight propensity to develop phobias. However, whatever mild pathologic or prepathologic elements were present were entirely attributable to the intrafamilial tension, and none at all to the surgical reversal of sex.

In the last examination, at age 5 years, 4 months, Alberta appeared much more feminine. Her play began with guns, but she quickly left these for pastel painting, dolls, and doll furniture. Her ideation bespoke a definite feminine identification. Her hair was curled, she wore fingernail polish, which was the remnant of "lady" play activity at home the previous day. Concurrently, the mother reported family events which showed a neurotic "resolution" of her own conflicts. She had two miscarriages in the past year and was now working full time. The husband in the meantime had slipped into a passive pattern. The mother seemed much more content in her "phallic" role and beamed feminine influence on Alberta. She reported what seemed normal play activity with the neighboring children and a normal adjustment in kindergarten. There were no behavioral items reported suggestive of any psychopathology.

Summary

Surgical treatment of a case of clinical pseudo-hermaphroditism is reported. Surgical reversal of assigned sex was performed at age 2 years, 4 months. A three-year follow-up suggests that there has been no adverse psychologic complication. It is suggested that the well established criteria for the age limit at which such a procedure may be safely undertaken may be modified somewhat upward, as our clinical experience in this area increases.

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44 South Munn Avenue

Here is a creditable piece of physiologic research by a second year student at the Seton Hall College of Medicine and Dentistry.

Catecholamine Depletion and Irreversible Shock††

Robert Pinnas, B.A./Jersey City

Shock often develops after a hemorrhage, operation, or injury. It pursues a progressive downward course and is likely to prove fatal if untreated.[1]

The problem of hemorrhagic shock has plagued scientific investigators since the beginning of rational medicine. The severity of the syndrome was catapulted to the fore by the many cases of vascular trauma encountered by front line physicians during two great wars. Vast amounts of research have been conducted and many interesting theories have been proposed; but, as yet, no one has been able to reverse the syndrome. This paper will attempt to examine the responses of a heart, depleted of adrenergic neural control, to experimental hypotension.

Reserpine† has been shown by Gaffney, *et. al.*[2] to release catecholamines from the atrial musculature of a dog's heart following intravenous injection. During a five hour period after injection, left atrial norepinephrine content decreased from levels ranging from 2.5 to 3.0 mcg/g (controls) to levels ranging from 0.2 to 0.9 mcg/g. These investigators conclude that the sympathetic nerve blockade induced by reserpine ultimately depends on an essentially complete catecholamine depletion of adrenergic transmitter stores.

It is the objective of this investigator to determine whether animals (chronically treated with reserpine† to produce catecholamine-depleted hearts) could withstand an irreversible shock producing procedure better than animals whose hearts have *not* been depleted of catecholamines. We worked with 15 pentobarbitalized, male dogs (8 control and 7 experimental). They were subjected to controlled hypotension by hemorrhage using the method of Wiggers and Werle (described below). The dogs were first anesthetized with 30 mg/kg sodium pentobarbital (20 mg/kg with the reserpinized dogs). Cannulae were placed in the carotid artery, femoral artery, and vein. Blood pressure was recorded via the carotid artery with two Statham strain gages calibrated to a reference zero level set at the surface of the animal board. Heart rate was recorded with a cardiotachometer; and abnormalities in rhythm and electrical conduction, with an electrocardiogram (EKG). Signals from the strain gages, tachometer, and EKG leads were recorded on an Electronics-for-Medicine® DR7 recorder. Photographic records were made of mean and pulse pressures, heart rate, and EKG at constant intervals (10 to 12 minutes) throughout the experiment.

The experimental animals were pre-treated with reserpine,† 20 mcg/kg orally, for 10 to 14 days before undergoing the procedure described above.

†† Mr. Pinnas is Summer Research Fellow of the National Institutes of Health. This work, supported by a grant from the Monmouth County Chapter, New Jersey Heart Association and the United Health Foundation, is from the Department of Physiology at Seton Hall College of Medicine and Dentistry in Jersey City.

† The author wishes to thank Dr. A. J. Plummer of Ciba for a generous supply of reserpine.

The irreversible shock producing procedure consisted of three stages:

First Stage—The anesthetized animal was given a one-half heparinizing dose and then bled from the femoral artery until the mean arterial blood pressure (MABP) reached 50 mm. Hg. The rate of this initial bleeding was about 50 milliliters per minute. Subsequent bleedings or reinfusions of blood were carried out when necessary to maintain this pressure for 90 minutes. The volume of extravasated blood required to reduce MABP to 50 was recorded.

Second Stage—At the end of 90 minutes, the animal was again bled from the femoral artery until the MABP* equalled 30 mm. Hg. Blood pressure was stabilized by means of a heated reservoir connected to the arterial cannula and raised to a height of 40.8 centimeters above the level of the animal board. Maximum duration of this period of hypotension was 60 minutes. Toward the end of this period, MABP often began to drop and it became necessary to reinfuse small amounts of blood to maintain the pressure at 30 mm. Hg. If the frequency of these reinfusions exceeded one per five minutes, the 30 mm. Hg. hypotensive period was terminated. The volume of withdrawn blood was noted at the close of this period.

Third Stage—At the termination of stage two, the withdrawn blood, which had been heparinized and kept in a 37 degree water bath, was rapidly reinfused via the femoral vein at a rate approximating 50 milliliters per minute. The time at which reinfusion was completed was noted. A 12 second photographic record of the oscilloscope tracings was made at the completion of reinfusion and subsequent records were made every 10 to 12 minutes until completion of the experiment.

The experiment was terminated if death from circulatory failure ensued within five hours after reinfusion, or if the animal's MABP* had not declined below 70 percent of control value within five hours. If the animal's MABP* had decreased below 70 percent of control before the five hour period ended, recordings were continued until death occurred.

Results

Eight control dogs ranging in weight from 12 to 16 kilograms were submitted to the shock inducing procedure described above. After reinfusion, five animals went into a state of fulminant shock, all dying of progressive circulatory failure in 40 to 274 minutes. Two animals experienced delayed shock, the MABP* dropping to below 70 percent of control value in less than five hours, and one animal failed to exhibit any signs of shock.

Seven reserpinized dogs ranging in weight from 12 to 16 kilograms were submitted to the shock-inducing procedure described above. After reinfusion, five animals experienced a state of irreversible shock, dying from circulatory failure in 120 to 348 minutes. Two animals failed to go into shock (see table 1).

TABLE 1

	Weight in Kg	Time of Death	Result
Control			
1	12.0	139	Shock
2	12.0	40	Shock
3	15.5	457*	No Shock
4	14.7	494*	Delay Shock
5	12.0	45	Shock
6	12.0	110	Shock
7	16.0	240*	Delay Shock
8	13.2	274	Shock
Experimental			
1	14.3	252*	Shock
2	15.7	514*	No Shock
3	13.4	336*	No Shock
4	12.0	120	Shock
5	15.0	348	Shock
6	12.6	144	Shock
7	13.4	228*	Shock

* Experiment terminated (Time in minutes from reinfusion).

According to those findings, it would appear that catecholamine depletion by reserpine treatment produced no significant difference in induction of a state of shock.

An examination of table 2, however, shows a considerable variance in the volume of withdrawn blood noted during the 30 mm. Hg. hypotensive period in the two groups of animals. Table 3 shows the results of the chi square significance test indicating strongly that a significantly reduced volume of blood was withdrawn in the process of maintaining the reserpinized dogs at the 30 mm. Hg. MABP* level.

* Mean arterial blood pressure.

TABLE 2

Control	Max. Ml/Kg Bled	
1	53.5	
2	60.0	
3	60.6	
4	51.7	
5	35.8	
6	50.8	
7	54.4	
8	56.7	$\bar{x} = 52.9$
Experimental		
1	40.6	
2	43.9	
3	53.0	
4	40.4	
5	37.3	
6	34.0	
7	48.0	$\bar{x} = 42.4$

TABLE 3

There is no difference between bleeding volumes in control or reserpinized dogs other than that due entirely to chance. But a chi-square value in excess of 20 may be expected to occur so infrequently by chance, that the discrepancy between observed and expected volumes must be considered real.

0	E	0-E	$(0-\xi)^2$	$\frac{(0-\xi)^2}{\xi}$
40.6	52.9	−12.3	151.29	2.859
43.9	52.9	−13.0	169.00	3.194
53.0	52.9	+ 0.1	0.01	0.0002
40.4	52.9	−12.5	156.25	2.953
37.3	52.9	−15.6	243.36	4.600
34.0	52.9	−18.9	357.21	6.752
48.0	52.9	− 4.9	24.01	0.454

Comment

Some factors other than the experimentally produced hemorrhage must be contributing to the reduction of MABP* in the reserpinized animals. Some of the possible mechanisms are as follows:

1. Arteriolar constriction associated with sympathetic discharge under conditions of circulatory embarrassment may be compromised as a result of the generalized catecholamine depletion. This would tend to increase peripheral run off and lower diastolic pressure.

2. Catecholamine depletion from the heart musculature itself might not only make it difficult for the heart to increase its contractile force in response to the increased demand made upon it during hemorrhagic hypotension, but might also weaken the heart so that it cannot develop its normal contractile force under resting conditions.

3. Among the established compensatory mechanisms that the body brings into play in defense against massive hemorrhage is reflex venoconstriction. This mechanism facilitates emptying of blood reservoirs and transfer of blood from the venous side of the circulation to the arterial side in an attempt to correct the decreasing MABP.* Gaffney *et. al*[3] have demonstrated that dogs under reserpine pretreatment do not exhibit a venopressor response to central vagal stimulation during major vessel occlusion (simultaneous occlusion of the thoracic aorta and post cava). It is possible that the decrease in bleeding volume required to stabilize a MABP* of 30 mm. Hg. in the reserpinized dogs in this report is due to an increased amount of blood left in the venous system subsequent to reflex venopressor failure. In such a situation, right heart filling would be reduced and cardiac output accordingly decreased.

4. Pharmacodynamically, it is an established fact that reserpine is an hypotensive agent and the experimental animals probably had a resting MABP* which was somewhat lower than that of the controls before the experiment was begun.

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24 Baldwin Avenue

An economist here puts right in our laps the problem of reducing the costs of medical care.

The Physician's Stake In Medical Economics

Sidney I. Simon*, Ph.D./New Brunswick

It is high time that the practicing physician began to concern himself with the sky-rocketing costs of medical care—most of which are due to rising hospital expenses. To the average citizen, the overall cost of medical (including hospital) care has risen at a rate more than double that of the average cost of living during the last twenty years. This has led to growing public resentment and lack of understanding of these rising costs. The constantly recurring requests for Blue Cross rate increases, as well as the growing proportion of the aged in our population vitally interested in the Medicare controversy, have fanned the flames of public indignation about medical costs, so that the topic has been in the news and magazine columns almost daily.

The worst offenders in this field are the costs of hospital care and health insurance. All medical charges have risen with the general inflation in the past twenty years. Surgeons' fees, for instance, have gone up an average of 26 per cent; general practitioners' fees, 39 per cent; and dental charges, 34 per cent. But hospital care rates have zoomed a steep 132 per cent in that period. The distribution of the medical care dollar has also changed dramatically. The cut of the "medical cost pie" spent on physicians has tail-spinned from 31 to 24 per cent, whereas hospitals now take 26 per cent instead of their previous 17 per cent of the medical care dollar. The health insurance ratio has jumped from 5 to 8 per cent. The medical doctor must now interest himself in the difficulties of medical economics and not merely in the problems of clinical practice. The practitioner has an enormous stake in this new discipline. This is especially true of the problems involved in rising hospital and health insurance costs. If something cannot be done to put a curb on the ever-increasing charges of Blue Cross and other health insurance programs (largely by applying a brake on skyrocketing hospital costs), the "Blue plans" and other insurance carriers will soon price themselves out of the market for the average subscriber. The alternative to these coverages will be a form of socialized medicine. Since the medical profession is probably the strongest opponent of Medicare and other even more drastic plans for the socialization of health costs, it should assert vigorous leadership in combatting these cost increases; or, in the words of the Report of the Commissioner of Banking and Insurance's Committee (which studied New Jersey Blue Cross rates in 1959 and 1960), "the goblins of socialized medicine will get them if they don't watch out!"

The medical practitioner is—or should be—the central figure. He can play a dominant role in the control of hospital costs. A peculiar philosophical dichotomy pervades this problem. Consider hospitals and nonprofit insurance programs. Are these (a) social welfare agencies, giving service regardless of costs? Or are they (b) business institutions which have to earn enough revenue to cover their costs?

The medical doctor, in his position of

* Dr. Simon is Professor of Economics at Rutgers. This paper was delivered, by invitation, to the New Jersey Welfare Council on October 28, 1964.

authority in the hospital (to whom both the administrator and trustees must listen), has the obligation of effecting some balance between these two viewpoints. They are not necessarily the antithesis of each other. The physician must act as the catalyst in trying to save lives, and also save the life of the hospital and our entire free enterprise approach to medical economics.

The Need For Capital Funds

A serious difficulty (and one which contributes considerably to increasing medical care costs) is that involved with the need for capital funds for hospital expansion. In most localities, there is increasing need for more hospitals. Our total population is rising dramatically. An ever-increasing proportion of the population is either composed of children or of very old people. Both these groups make considerably more use of hospitals than do those in the 20 to 60 age brackets. In addition, there has sprung up in recent years a greater acceptance of the hospital by all people, and a disappearance of the old fear of a hospital as a place where one went only to die. The "Blue" plans (and most other health coverages) encourage the need for more hospitals, since most of them require hospitalization if the subscriber is to collect on his insurance.

Coupled with the need for more hospitals is the additional requirement for capital funds to finance the continual need for newer types of hospital equipment. New medical inventions and discoveries are constantly adding to equipment requirements. Many of these devices are too expensive to be part of the equipment of the doctors' own offices; thus they must be placed in the hospitals, which have become the workshops for the medical practitioners.

As their capital needs grow greater, hospitals find their sources of such funds drying up. Traditionally, hospital capital funds have been supplied either by county or municipal appropriations or by endowments or gifts from charitable sources. Today, however, by and large the community has not been adequately furnishing hospital expansion funds through either of these approaches. Governmental bodies (their budgets burdened with all the other costs with which they are now saddled) have been unable to meet expanding hospital needs. Charitable contributions, as a source of such funds, have been diminishing. To some degree, the existence of Blue Cross has psychologically hurt public contributions to hospitals, because the public mistakenly believes that Blue Cross provides the hospitals with adequate financial support. The amounts called for in most Blue Cross reimbursable cost formulas, however, do not allow nearly enough for capital expansion of hospitals. Most charitable organizations today contribute to hospitals only isolated pieces of complicated equipment which, by their very presence and operation, add to the costs of running the institution and to the overall use of the hospital.

Therefore medical doctors, as respected professional men in their communities, and medical societies, as influential organizations, must take the lead in publicizing the needs of hospitals for capital funds. Then, county and municipal authorities and charitable organizations will reawaken to the need for their greater support for these purposes.

Indigent Patient Costs

A serious difficulty faced by public hospitals is that of caring for the medically indigent patient. The mores of our present society call for equal care for the charitable and for the paying patient. The old fashioned "ward" has disappeared from most of our hospitals. Yet governmental bodies are woefully deficient in covering hospital costs for indigents. Blue Cross, which pays for as much as 70 per cent of the bills of patients in many hospitals, does not contribute one penny toward the cost of indigent patients. In New Jersey, the County or City pays (on the average) about $9 a day for an indigent's daily hospital bill which actually costs over $30 a day. The hospital, unable to spread that $21 deficiency among its few patients paying their own bills, finds the care of these indigents a severe strain on its budget.

Here again the doctors and their medical societies should take the lead and exercise their potent influence to get governmental bodies to appropriate adequate amounts for care of the medically indigent. Doctors should not further injure public hospitals by "creaming off" the wealthy and well-paying patients by admitting them to proprietary institutions, while sending only the less affluent ones to public hospitals. The very existence of the proprietary hospital (often doctor-owned) greatly aggravates the indigent care problem of the public hospital through this irresponsible attitude of some medical practitioners.

Hospital Location And Specialization

Most localities need more hospitals. Not all do, however, and one area of hospital operating cost difficulty arises from haphazard location of hospitals and choice of sites, or from excessive specialization. Some institutions are so crowded that patients sleep in cots in the corridors. Yet occasional hospitals are built in localities of insufficient need and suffer from low occupancy ratios. Lack of specialization of two or more hospitals in a single geographic area may lead to tremendous cost through duplication of expensive and seldom used equipment. But other hospitals may be so over-specialized that they suffer from excessive costs due to low occupancy rates.

The question of proper hospital location also affects varying hospital costs in other ways among institutions, such as differences in "patient-mix," the type of average patient, his general affluence, typical diagnosis, and average length of stay. It affects the standards for the staff and nursing care, as well as rates of pay for professional and other employees. Location even has some effect on the age of the hospital buildings and the amount and type of equipment in them.

This is again an area in which the medical practitioner should take an interest and assert leadership. Sites for new hospitals should not be chosen without the approval of the local medical society which, in turn, should study the problem thoroughly before giving its assent. The society should also interest itself in the details of construction, the degree of specialization, and the selection of equipment for the new hospital. If hospitals are geographically near each other, it might be possible to encourage the plan of "corresponding hospitals," with each specializing in certain fields only, and referring patients to the other institution for the specialty of the latter. If there is a centrally located general hospital, institutions newly built in outlying areas might be organized as "satellite" hospitals connected with the central one, giving care to routine diagnoses but sending more difficult and specialized cases to the general central hospital. These satellites could cut costs by using the accounting, dietary, legal, public relations, and management services of the central hospital.

Hospital "Hotel" Costs

Another area which contributes considerably to rising hospital charges is that involved in the costs of running an institution where people eat and sleep, rather than one where they come for strictly medical problems. Not only has there been terrific inflation in the cost of supplies, but hospital labor costs have soared 545 per cent in the last twenty years. Two-thirds of all hospital cost is payroll. This leads to great problems. Compounding the difficulty is that the average hospital uses 2½ employees per patient today as against 1½ two decades ago. Furthermore, some hospitals are still not completely on three shifts a day for their employees. Wages of most hospital workers are still below that of comparable positions in industry.

While cutting "hotel-type" costs is largely the task of the administrator, the medical staff can aid. One way is to help in putting the hospital on a seven-day instead of a five-day week, so that patients do not have to stay in a hospital over a week-end when most departmental operations are dormant. A hospital must be a hospital on Saturday and Sunday, too, and not just a hotel.

Doctors should take the lead in the establishment of "Progressive Care" units and self-

service areas in their hospitals, and should encourage the administrator to institute cost-cutting ideas and devices, such as standardized supplies, use of disposable items, centralized purchasing, automation, cost accounting and data-processing, as well as management and industrial engineering studies and assistance in increasing hospital efficiency.

Overutilization

An area of hospital, and particularly health insurance, cost over which the medical practitioner has perhaps the most direct control is that of unnecessary utilization of the facilities. Hospital usage has increased in the last twenty years for a variety of reasons, some of which are due to present day sociologic and economic factors. The very large proportion of working wives and mothers fosters hospitalization of sick husbands, children, or parents, as does the fact that smaller modern apartments and homes do not have an extra room which can be used as an isolation or "sick-room" at home. Most people today readily accept hospitalization as necessary for good treatment. Typical is the utilization of hospitals for obstetrical procedures. At the turn of the century, most babies were delivered at home. In New Jersey today, practically 100 per cent of deliveries are in hospitals.

Certain oddities of health coverage and non-profit insurance have magnified the problem, since hospitalization is required in so many policies if the subscriber is to collect on the insurance. This has led to unnecessary hospital admissions or overlong stays. The desire of some subscribers to get their money's worth out of years of premium paying has been a factor, as has been the fact that there are no *pro-rata* liability clauses in most health insurance policies. Today, duplication of such coverage by subscribers with more than one hospital insurance policy can lead actually to making money out of a hospital stay.

Part of the problem of hospital overutilization, however, is under the physicians' control. Modern treatment has cut down on the average stay in a hospital. This has contributed to the higher daily cost per patient. One has only to consider the change in hospital treatment of tuberculosis, for instance, to see the application of this point. In addition, because the hospital has become the physician's workshop, he tends to hospitalize patients who might have been treated in his office or at home years ago. This is not only because the hospital has the expensive equipment the doctor does not have in his own office, but also because the physician can see more patients in a shorter time if many of them are in beds in the same hospital.

The medical practitioner must take the lead in controlling overutilization. Utilization committees, tissue or audit committees must be set up. They must have the power and the courage to carry out their objective. In some hospitals, the administrator has authority to suspend doctors who abuse utilization. In others, the committee takes the necessary step, but every hospital should have some method, with teeth in it, for curbing these abuses.

A joint study is now underway, sponsored by the Blue Cross, Blue Shield, the New Jersey Hospital Association, and The Medical Society of New Jersey. The hope is to arrive at realistic standards for average length of stay in hospitals. All medical practitioners should actively cooperate in this study project. Once averages are worked out, and found acceptable by the practitioners, it would be well to require physician recertification for hospital stays beyond the new standard set for that illness rather than the blanket fourteen-day recertification that the "Blue" plans now require.

Upgrading The General Practitioner

A problem that indirectly and in the long run affects medical costs is that of the gradual disappearance of the general practitioner. The tendency toward medical specialization has resulted in increased fees for the patient. It has raised hospital costs by greatly increasing the use of the Emergency Room for treatment formerly done by the general practictioner. The medical profession must take the leadership in encouraging general practice. The

status of the general practitioner among his professional colleagues (and especially in the hospitals and medical schools) should be recognized and appreciated. Attempts should also be made to get a better geographic spread among medical doctors. If the present state of medical economics has indeed completely doomed the family doctor, then at least the formation of more medical groups should be accomplished to replace him, if for no other reason than to ease the growing burden of the hospital Emergency Room of the many types of treatment they must give today that were not part of their services in the past.

The Doctor Must Say "No"

A final and indispensable step in the battle to cut down medical costs is this: the medical practitioner has to have the courage and willingness to say "no" to the patient who seeks unnecessary or overlong hospitalization. Diagnostic tests should, where possible, be done in the practitioner's office or in an outside laboratory. Some doctors are afraid that if they say "no," they will lose the patient to a more compliant practitioner. This fear would be groundless if the county medical societies would hold the line here and insist that all its members show this kind of courage.

If you talk to the average persons in the general public today, you will find many of them already shrugging their shoulders and saying socialized medicine is inevitable in this country—it is just a question of when it will be instituted. If this socialization of medicine is to be avoided, it is the medical practitioner who must take the leadership in combatting it. He must not only interest himself now in the problems of medical economics, but must take active steps immediately, both as an individual and through his medical society, to do all he can toward curbing the chronic increases in health and hospital costs.

The College of Arts and Sciences of Rutgers University

199th ANNUAL MEETING

Saturday-Wednesday, May 15-19, 1965

Haddon Hall, Atlantic City

Saturday — House of Delegates

Sunday — Reference Committees
House of Delegates (election)

Monday — Scientific Sessions
Annual Dinner-Dance

Tuesday — House of Delegates
Special Scientific Sessions
Reception for Incoming President

Wednesday — Scientific Sessions

Mark these dates on your calendar and plan to be present.

Syphilis is epidemic in New Jersey, and every physician has an important role in controlling this ancient scourge.

Syphilis: An Old Enemy On the March*

William J. Dougherty, M.D.† M.P.H.
Trenton

In New Jersey, there has been a gradual decline in the numbers of total cases of syphilis from a peak of over 10,000 cases in 1941 to 5,664 cases in 1963. We are fully aware of the importance of the marked decline in primary-secondary syphilis that occurred between 1945 and 1955. In this period, at the height of the use of penicilin, clinical lesions of primary-secondary syphilis practically disappeared to an extent that many believed that the disease was completely controlled.

In this same period, early latent syphilis was reported at a rather steady pace of approximately 1,000 cases a year. Many were detected in extensive mass blood testing surveys. Frequently, the diagnosis of early latent syphilis was based upon reactive serology, a history of promiscuous sexual activity, and an indifferent history of a lesion. Many of these early latent cases passed through the primary-secondary stage unrecognized or presented lesions modified by inadequate penicillin therapy. The continued incidence of early latent syphilis indicates that at least 1,000 cases of primary-secondary syphilis were occurring each year and were not recognized, reported or investigated. This was a situation scarcely deserving the optimism created by the decline in recognized cases of primary-secondary syphilis.

The decline in early latent syphilis in 1955 and 1956 can be traced directly to the reduction in community mass serologic testing, and the rising incidence between 1957 and 1963 is related to the gradual evolution and extension of selective serologic testing of suspects and associates of cases of primary-secondary syphilis.

The progressive rise in incidence of cases of primary-secondary syphilis began in 1958 and reached a peak of 1,202 cases in 1962. In the following year, 1,187 cases were reported—a decline which was not significant. A monthly average of more than 100 cases of primary-secondary syphilis is not unusual in New Jersey.

We know from experience that if each case of primary-secondary syphilis is intensively investigated, the source of infection can be found and persons to whom the infection has been spread can be found also. Simply stated, for every case of primary syphilis reported, we should expect to find at least one source case of secondary or early latent syphilis. For every case of secondary syphilis reported, we should expect to find at least one source case of early latent syphilis. For every case of primary syphilis reported, we should expect to find among its contacts at least one spread case in the primary stage. Also, for every case of secondary syphilis reported, we should expect to find among its contacts at least one spread case of primary syphilis. If these conditions are carried to their conclusion, more cases of primary-secondary syphilis should be discovered than cases of early latent syphilis. Since 1960, more cases of primary-secondary syphilis have been discovered and reported than cases of early latent syphilis.

In 1947, the case rate of primary-secondary syphilis was nearly 40 cases per 100,000 population. The rate of reported cases declined to

† Dr. Dougherty is Director of the Division of Preventable Diseases in our State Department of Health. This was adapted from a paper on the subject, presented by Dr. Dougherty at our May 1964 Annual Meeting in Atlantic City.

* Read May 20, 1964 at the Annual Meeting of the M.S. of N.J.

less than 2 cases per 100,000 in 1956. The acute resurgence of primary-secondary disease in the next 7 years is evident. The trend of increase exceeded the preceding trend of decline. In 1962 and 63, the rate of primary-secondary syphilis was 9 times that of 1956.

PRIMARY-SECONDARY SYPHILIS

RATES PER 100,000 NEW JERSEY 1958-1963

YEARS	1958	1962	1963
UNDER 1			1.5
1-4		0.4	
5-14	0.6	2.6	0.8
15-19	7.1	39.1	38.6
20-24	13.5	106.4	107.3
25-44	5.0	35.3	31.3
45 /	0.6	3.3	3.1

Table 1 presents age specific rates of newly reported primary-secondary syphilis in New Jersey for a period of 6 years. These rates leave no room for complacency. *Among teenagers, the rate of new primary-secondary disease has increased almost 6 times.* We can truthfully say that syphilis is epidemic among persons between 15 and 24 years of age in New Jersey. This fact requires the mobilized efforts of every medical practitioner in our state.

The reporting of cases of primary-secondary syphilis to the public health authorities of a state is the very base of any effort to control and eradicate this disease. Without the case report, the extensive epidemiologic process necessary to locate source and spread cases throughout this country and abroad cannot be initiated. Every physician diagnosing a case of primary-secondary syphilis has a manifest, unavoidable responsibility to report the case to the State Department of Health.

A study[1] conducted in 1963 by the American Social Health Association, the American Medical Association, and the United States Public Health Service revealed that private physicians were treating approximately 75 percent of all venereal disease cases in the U.S. This survey showed that the responding physicians treated 13,930 cases of primary-secondary syphilis between April and June 1962. But in that period, only 1,576 cases of primary-secondary disease were reported to health authorities. Thus, only 11 percent of primary-secondary syphilis treated by private practitioners was reported. From Table 2 it is evident that less than 25 percent of primary-secondary cases in New Jersey are being reported. This situation needs to be corrected. Patients who are not reported are lost to the investigative process and to epidemiologic control. The contacts of unreported cases are then free to develop their infection and to spread it to others. This undetected, progressively increasing transmission gives rise to the current resurgence of syphilis in epidemic form.

INFECTIOUS SYPHILIS

TREATMENT & REPORTING

UNITED STATES

APRIL-JUNE 1962

	PRIMARY SECONDARY SYPHILIS		
AREA	TREATED	REPORTED	PERCENT REPORTED
UNITED STATES	13,930	1,576	11.3
NEW JERSEY	542	121	22.3
NEW YORK	1,807	389	21.5
PENN.	937	52	5.5
S. CAROLINA	226	56	24.8

To stem this tide of infection, it is necessary to destroy the treponeme *before* it sheds its organisms to infect others and *before* it produces new lesions. Destruction of the spirochetes cannot take place if cases of primary-secondary syphilis are not reported at the time of diagnosis.

The private practitioner has a major and inescapable function in the control and eradication of syphilis. His responsibility to society is as important as his concern for the privacy of his patient, a privacy which our investigators protect. The physician can carry out his role best by reporting diagnoses of primary-secondary disease immediately. Investigative activity begins with the receipt of a case report of primary-secondary syphilis. The case is assigned to a trained venereal

disease investigator who must establish rapport with the reporting physician in order to develop information concerning the patient that will assist in the epidemiologic interview. The investigator must then locate the patient and establish an opportunity to interview him. He must gain the confidence of the patient in order to develop a general history of his sexual activity and specifically interview the patient concerning contacts during the critical incubation period of primary-secondary syphilis. This interview is to obtain names and addresses of the specific sex contacts from whom the patient may have acquired his disease and to whom he may have spread it. In addition, since the patient is a part of a social sexual community, he is interviewed for knowledge of others whom he knows would benefit from a serologic test for syphilis. In this way, the patient is able to assist in the selective screening of persons who he knows engage in promiscuous sexual behavior.

Having determined the names and addresses of the specific sex contacts of the patient, the investigator must locate the contacts and assure that they receive diagnostic services either in the office of a private practitioner or in a public clinic. In addition, the investigator must offer all associates who have been named by the patient the opportunity to participate in a serologic test for syphilis. This testing procedure is known as cluster testing.

Field investigation of contacts has been carried out with increasing efficiency. Only 45 percent of the primary-secondary syphilis cases reported in 1960 were brought to treatment by field investigative activity. In 1963, of the 1,187 cases of primary-secondary syphilis reported, 887 or 75 percent were brought to diagnosis and treatment by field activity. Also, in 1963, 316 of 840 cases of early latent syphilis were brought to diagnosis and treatment by field investigative activity.

The measurement of epidemiologic success provides a control on field investigative activity. A case of primary-secondary syphilis is counted as an epidemiologic success if a source or spread case of primary-secondary or early latent syphilis is discovered among its contacts. During 1963, New Jersey clinics reported 613 cases of primary-secondary syphilis cases. Epidemiologic success was achieved on 503 or 82 percent of these cases. In comparison, private physicians reported 574 cases; epidemiologic success was attained on only 52 percent.

A recent New Jersey study revealed that the shorter the time interval between the reporting of a case of primary-secondary syphilis and the interview of the patient, the greater the probability of epidemiologic success. An ideal situation would exist if private physicians would report *all* cases of primary-secondary syphilis *while the patients are still in their offices.* The impact of the epidemiologic interview is greatest at this point, immediately after the diagnosis has been established and treatment for the disease has been given. This fact is critically important when one considers that 24 percent of private physician cases of primary-secondary syphilis could not be located for interview in 1963. This factor coupled with that of gross under-reporting of primary-secondary disease makes successful epidemiologic control of primary-secondary syphilis very difficult.

The New Jersey State Health Department provides benzathine penicillin† for the treatment of clinical syphilis. Epidemiologic treatment of contacts is recommended.

The rational of epidemiologic treatment stems from the pathogenesis of syphilis. When the treponeme gains admission to the body and settles in the tissue, there is reproduction at the site of entry and shortly thereafter dissemination through the body via the lymph and blood streams. In most instances, infection is followed by a visible tissue reaction and a lesion at the site of invasion. This lesion is infectious.

Generalized lesions and tissue reactions follow the dissemination of organisms throughout the body. These lesions are infectious. It is important to remember that the local or generalized lesions may fail to occur or may be so slight as to escape notice, and such symptomless infection may be unsuspected until a reactive serology at some later time

† In the form of Bicillin® Wyeth.

leads to the diagnosis of syphilis. When undetected syphilis exists, the potential for transmitting infection exists and its spread is unpredictable. The resurgence of syphilis in epidemic form depends upon progressively increasing transmission of treponemes from symptomatic and symptomless lesions. To stem the tide of infection, it is necessary to destroy the treponeme before it produces a tissue reaction or a lesion which sheds new organisms to infect others. This destruction should take place within the average incubation period of three weeks. The earlier in the course of infection the treponeme is destroyed, the more effectively is the spread reduced and the propagation of new lesions controlled.

Epidemiologic treatment is given to destroy all treponemes within the body and to arrest the development of infectious syphilis in an exposed sex contact who does not have symptoms or signs of syphilis. Moore[2] recently reported a study of 788 clinically negative and serologically negative contacts of infectious syphilis. Six hundred seventy-three (85 percent) were followed from the initial examination for a period of at least three months. Sixteen contacts in the placebo group who received no curative antibiotic developed clinical syphilis within the three month follow-up period. This rate of 9 percent provides an indication of the risk of syphilis among the clinically negative, serologically negative contacts whom we frequently classify as noninfected and do not follow. We have previously reported[3] that in New Jersey, among 978 contacts of infectious syphilis examined between January and June 1961, there were 398 cases of infectious syphilis—an attack rate of infectious syphilis of 41 percent. There is urgent need to increase the extent to which epidemiologic treatment of the sex contacts of primary-secondary syphilis cases is provided.

Syphilis is epidemic in New Jersey; underreporting of primary-secondary syphilis is evident; only one of every four cases of primary-secondary syphilis treated by a private physician is reported; only 52 per cent of cases reported by private physicians yields an epidemiologic success; and many sex contacts in this State require epidemiologic treatment.

There is need for an effective plan for the future. A partial answer may be found in the concept of immediate response epidemiology. Under this concept, the State Health Department is prepared to provide darkfield examination services to assist in the diagnosis of primary-secondary syphilis at any time, anywhere in the State. The physician has only to call the Department answering service telephone 609-392-2020, and every effort will be made to have an epidemiologist report to the physician's office at an appointed time or within an hour or two after receiving the request. Many physicians have already used this service when they discovered a case of suspected primary-secondary syphilis. Many physicians make an appointment for the patient to return on the following afternoon or evening. They call the Department and arrange for an epidemiologist to be in the office at that time. They provide space and privacy for a darkfield examination of the suspected lesion. In doing this examination, the epidemiologist has the opportunity to develop rapport with the patient. If the diagnosis of primary-secondary syphilis is confirmed, the epidemiologist immediately prepares the case report for the physician and conducts the epidemiologic interview of the patient in one complete service. This activity envisions the private practitioner as the central member of the primary-secondary syphilis epidemiologic team.

The State of New Jersey wishes to extend the long history of cooperation between the State Health Department and the private practitioner in the treatment of syphilis by extending the service of immediate response epidemiology to the practitioner's office. The assistance of every physician in this State is urgently needed if we are to stem the rising tide of epidemic syphilis.

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Allylestrenol improved the fetal salvage rate from 59 to 90 per cent in this series of habitual or threatened aborters.

Clinical Evaluation of Allylestrenol in Threatened Abortion

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A review of the statistics published by the U.S. Public Health Service[1] on fetal loss from all recorded pregnancies shows the following annual percentage of pregnancies that terminated in failure:

	per cent
1957	21.8
1958	22.1
1959	21.8
1960	22.2
1961	22.7

In essence, there has been no improvement in fetal salvage during these five years and probably the same general ratio exists at present, even though orally active progestional agents for maintaining pregnancy had been available.

Progestogens have not been used more vigorously to reduce fetal loss because of undesirable side effects. The two most important have been symptoms of intolerance and a tendency to virilisation; the latter, arising from the androgenic activity exhibited by some of these substances. Goldfarb[2] stated that the androgenic side effects associated with certain progestogens in the support of human pregnancies may be related to the dose, duration of therapy, and the time the progestogen was begun in the pregnancy. Here, then, are other causative factors beside side effects that keep the ratio of fetal loss at the same level during recent years. Ideally, a progestogen should exhibit potent progestational activity and be devoid of androgenic, estrogenic, and gonadal-adrenal inhibiting properties; no impairment of pregnancy and no influence on the external genitalia of the fetus. Only through continued research can the ideal be created.

One of the newer members of the progestogen group is allylestrenol.* Although it is pharmacologically less active as a progestogen than some members of the group, it seems to be completely free from androgenic and estrogenic activity,[3] and is exceptionally well tolerated.[4]

Overbeek, *et al.*,[5] reported on the animal pharmacology of allylestrenol and found it orally active in the Clauberg assay, the mouse deciduoma test, and in maintaining pregnancy in spayed rats. They said that allylestrenol* has twice the effectiveness of dimethisterone and eight times that of ethisterone as a pregnancy-maintaining steroid in experimental animals. The latter claim stimulated our current investigation of allylestrenol, since we previously reported on ethisterone in the treatment of threatened abortion and found it extremely effective in maintaining pregnancy.[6]

Substantial clinical evidence attesting to the progestational activity of allylestrenol as an agent for fetal salvage has been reported.[7,8,9,10]

* Tradenamed as Gestanin® by Organon, Inc., West Orange, N.J.

In our study, 61 obstetrical patients classified as threatened or habitual aborters were treated with allylestrenol,* one tablet (5 mg) four times a day. Supplemental medications for proper nutrition and rest were prescribed as indicated. We grouped our subjects into two classes:

1. *Threatened Aborters*—patients with persistent symptoms of vaginal bleeding (spotting) or cramps, with or without intermittent pelvic pains. Also, abortion-proneness induced by endocrine or metabolic dysfunction.

2. *Habitual Aborters*—patients who have a previous history of aborting three or more times, consecutively.

Conscientious efforts were made to rule out reproductive abnormalities and to obtain adequate information in the following categories in order to assay the patients' status and progress:

(a) *Past History*—Previous gynecologic operations or endocrine disturbances. Age of onset of menstruation, frequency and duration of flow. Any living children, length of gestation and type of delivery. If aborted, when terminated and was dilation and/or curettage done? Type and character of complications with previous pregnancies. Familial hypertension, diabetes, tuberculosis, mental disease, congenital abnormalities, or nephritis.

(b) *Current Laboratory Data*—Degree of bleeding or spotting. Nausea, vomiting, headaches or visual disturbances. Temperature, blood pressure, pulse, respiration rate. Blood type, Rh factor, blood count, hemoglobin, serology, bleeding time, clotting time, hematocrit, urine analysis, and thyroid function.

(c) *Length of Gestation*—If aborted, length of gestation is recorded; and if possible, the causative factors are pin-pointed.

(d) *Delivery Data*—Previous and present type of delivery are meticulously recorded.

The length of gestation from previous pregnancies and the type of delivery from present pregnancies are shown in the tables. Table 1 grades our subjects by the number and percent of miscarriages.

TABLE 1
NUMBER AND RATIO OF PREVIOUS MISCARRIAGES

No. of Previous Miscarriages	No. of Patients	Percentage
0†	25	41
1	23	38
2	7	10
3	4	7
4	1	2
5	1	2
Totals	61	100

TABLE 2
TYPE OF DELIVERY

	No. of Patients	Percentage
Spontaneous	41	75
Forceps	5	9
Caesarian	9	16
Totals	55	100

TABLE 3
RESULTS:
PREVIOUS AND PRESENT PREGNANCIES

	Pregnancies	Miscarriages	Live Babies	Percentage of Success*
Previous Status	142	58	84	59
Present Status	61	6	55	90

Results

Comparison of results (Table 3) shows a 90 per cent success in delivering live babies from 61 pregnancies treated with allylestrenol.* This is a 31 per cent increase in fetal salvage when compared with 59 per cent of success from 142 previous pregnancies not treated with allylestrenol.

No masculinization of mother or baby or any other side effects were observed during hospital confinement or at the routine postpartum study.

Correlation of data on past history and current laboratory tests revealed no factors that would be considered contributing causes to the patient's status as an aborter.

Only two premature babies, delivered by caesarean, were obtained in our series weighing less than 4 pounds. All others were of normal birth weight.

Summary and Conclusions

1. Sixty-one obstetrical patients, classified as threatened or habitual aborters, were treated with allylestrenol,* a progestional agent for maintaining the conceptus.

* Note the 31 percent increase in fetal salvage with allylestrenol.

† Those patients with no history of miscarriages had bleeding complaints, with or without pelvic pains, from their present pregnancies. One patient in particular (Case No. 47) had bleeding throughout her gestation period with the exception of the last two weeks before parturition.

2. The previous obstetrical history of each patient was used as a control in comparing the degree of success with allylestrenol* in fetal salvage. Past history and clinical laboratory data were carefully scrutinized to determine significant or contributing factors responsible for the abortive proneness of the patients.

3. Approximately 75 per cent of the patients were delivered spontaneously. The remainder were delivered by forceps (mid or low) and by caesarean. A 90 per cent success in delivering live babies was obtained from treatment with allylestrenol.* Previous pregnancies from the same group of patients resulted in live babies in only 59 per cent of deliveries.

4. We conclude (from a comparison of previous and present pregnancies which shows a 31 per cent increase in fetal salvage) that allylestrenol* is an effective progestational agent and seems to be devoid of any side effects within the limits of our observations.

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Pharmaceutical Companies and Graduate Education

A British report from the "Research Project on Prescribing," University of Liverpool, deals with "the extent to which a doctor interprets and correlates his scientific information when he is applying it to the needs of individual patients." The report is concluded by these observations: "Medical training, the pharmaceutical industry, the *British National Formulary* and consultants were each employed to provide over 20 per cent of the information which general practitioners need for treating patients. Information from the drug industry was used for 60 per cent of the diseases." Our observations over the years would lead us to believe that what was found to be true in England, is probably true in the United States. It points up the contribution which the pharmaceutical manufacturers are making to graduate education of family physicians in this country. In this effort the industry should be aided in every way by investigators, and government, so that clinical information may be quickly made available to those who treat the bulk of disease, the family physicians of the United States.—Perrin H. Long, M.D., in *Medical Times,* Dec. 1963.

The average woman, writes Dr. Spritzer, can bring forth her child by her own efforts. The opinions expressed, are of course, the author's, not necessarily the views of our Society.

The Case for Non-Interference in Obstetrics

Theodore D. Spritzer,† M.D./Dunellen

Most women will have an uncomplicated uneventful delivery if they are offered minimal analgesia and anesthesia and maximum emotional support. The value of psychologic care (soothing anxiety, eliminating loneliness and encouraging relaxation) is gaining intellectual acceptance from an increasing number of physicians. However, contemporary obstetrical practice is so dominated by the tools of "benevolent interference" that such basic principles are often obscured or ignored.

Consider, for example, the following practices —all of which are more or less routine labor and delivery room procedures:

Artificial rupture of the membranes.

Pushing on the fundus.

Elective use of forceps.

Elective induction of labor.

Acceleration of labor with oxytocin drips, injections or nasal sprays.

Manual dilatation of the cervix.

There are times, of course, when any of these may be lifesaving, or at least therapeutic. Even the most liberal advocates of natural childbirth are careful to state their approval of prompt intervention in an abnormally prolonged or arrested labor. In this paper, however, let me focus on the norm, the average, the routine labor and uncomplicated delivery.

Why interference? Physicians choose to speed the course of labor for a variety of reasons. Patients may beg for drugs to initiate or hasten labor: there is always the woman who insists upon producing a baby on her husband's birthday. The clamor of an anxious, waiting family can lend considerable impetus to an inclination to intervene. But (despite protestations to the contrary) the primary reason for obstetrical intervention is the convenience of the physician. A predilection for "daytime obstetrics," the pressures of an office practice, or the urgent knowledge of another patient in active labor enhances the attractiveness of time-saving devices and technics.

Why not interference? After thirty years of obstetrical practice—including a wide sampling of each of the above named methods—it is my conclusion that interference in a normal pregnancy, labor, or delivery, results in more harm than good. These methods can introduce complications in what should have been an orderly, spontaneous birth.

Dilation of the cervix is precipitated by a periodic increase in amniotic fluid pressure accompanied by the spreading action of the advancing vertex once the cervix begins to dilate. Cervical ripeness is almost unmistakeable: the os admits two fingers and is easily distensible. The more ripe, the more responsive. Despite such clear and unmistakeable guides, many physicians have an almost irresistible urge to stretch an incompletely dilated cervix to hasten completion of the first stage of labor. Such action damages the cervix. Moreover, it is likely to leave the patient with tough resistant scar tissue to impede the progress of future labors.

Amniotomy can open an avenue to ascending infection, particularly if the resultant labor is

† Dr. Spritzer died on January 24, 1965.

thereby prolonged. Prolapse of the cord and displacement of the presenting part are other real dangers.

A heavy hand can push on the fundus to hasten the expulsion of a placenta that will separate in good time. This can cause direct trauma to uterine musculature as well as contribute to excessive postpartum bleeding.

Even the skillful use of forceps introduces unwanted pressure against the fetal head and maternal parts. The results of unskilled use of forceps are too well known. Tissue damage is greater and, in addition, the rapid, inexpert extraction of the fetus in the second stage can leave an empty space to be filled with blood. In the normal course of events, the uterus contracts as the baby is born, leaving no such dangerous void.

Perhaps the area of greatest offense centers in the overconfident use of oxytoxic drugs. No one has yet devised the means to predict the response of a particular uterus to a given dose of oxytoxic. Furthermore, the fundamental requirements of watchful continuous attendance and extreme caution are often overlooked.

Elective induction may be physiologically ill-timed. Continued stimulation of the uterus can result in a prolonged exhausting labor or an abnormal presentation. Or the tumultuous labor that frequently follows oxytoxic stimulation may result in lacerations of the cervix, destruction of normal cervical contours, and the nightmare possibility of a ruptured uterus or fetal mortality and morbidity.

In an overstimulated uterus, the fundus can relax dangerously, resulting in hemorrhage. Long term consequences include erosion, eversion, chronic cervicitis, and predisposition to cervical carcinoma.

Lest this paper sound like a plea for a return to the rigors of the stone age, let me hasten to repeat that conditions such as true uterine inertia, incoordinate action, or distocia for any reason require prompt evaluation and intervention to prevent maternal and fetal exhaustion and injury.

There is room for much dialogue between the extremes of imprudent interference and complacent neglect. What, for example, does a diagnosis of "no progress" in labor really mean? In some part of the United States, twelve hours of labor with no measurable increase in cervical dilation is considered the cut off point for non-intervention. In some parts of Europe, interference is not countenanced until a woman has labored up to thirty hours without marked progress. In general, it seems safe to say that 12 to 20 hours of labor for a primipara and 8 to 12 for a multipara is ample indication for consultation and total re-evaluation. After 24 hours of non-productive labor, there is rapidly increasing danger for both mother and child.

While there is ample and impressive evidence in the literature on the effects of hasty premature interference in a normal labor, there is less but equally impressive indication that the conservative management of labor is neither outdated nor about to be replaced by any known tool or drug. The enviable record of well-trained, registered, nurse-midwives cannot be ignored. In 1961, The Frontier Nursing Service reported 4,000 consecutive deliveries without the loss of a single mother. Nurse-midwives get their fair share of dangerous cases, but their team approach coupled with individually oriented conservative obstetrics has yielded an infant and maternal mortality rate that could be the envy of many large and well equipped city hospital maternity services.

Conclusion

There is nothing new or startling in these statements; they are merely the reiteration of obstetrical knowledge long recognized. However, like any old truths, they must be periodically restated if they are not be become stale and empty maxims.

In this spirit, perhaps it is appropriate to insist once again that the average woman can, without the wondrous tools of obstetrical science, bring forth her child by her own efforts.

360 Mountain View Terrace

STATE ACTIVITIES

Trustees' Minutes

January 20, 1965

A regular meeting of the Board of Trustees was held on January 20, 1965, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the Secretary of each component society. A summary of the significant actions follows:

AMA-ERF . . . Received and noted acknowledgment from the AMA of MSNJ's AMA-ERF contribution of $32,490—presented by President Calvin during the 1964 AMA clinical convention.

Cardiovascular Diseases . . . Named Dr. Jerome G. Kaufman of Maplewood as the Society's representative to a committee to follow up the National Conference on Cardiovascular Diseases.

Physical Fitness Clinic . . . Endorsed the regional physical fitness clinic to be held in Harrisburg, Pennsylvania, March 22 to 27, by the President's Council on Physical Fitness; authorized President Calvin to attend.

Auxiliary Membership . . . Rejected the Auxiliary proposal that membership of a physician in a component society automatically include membership of his wife in the Woman's Auxiliary, with the bill for both memberships being paid by the physician; reaffirmed MSNJ policy not to impose membership in the AMA on its members or those of the Auxiliary, declaring that the same principle applies to county and state auxiliary membership.

Membership Directory . . . Called attention to the fact that all members have now received their copies, and commended the staff for the good work done on this publication.

Kerr-Mills Conference . . . Commended Dr. Matthew E. Boylan of Jersey City for his excellent report to the Board on his attendance —as the Society's representative—at the AMA Conference on Kerr-Mills; directed that this report be supplied to the members of the Society's Committee on the Chronically Ill and the Aging, with the request that this committee consult with proper state officials toward possible improvement of the New Jersey MAA Program.

7th AMA Delegate . . . Unanimously elected (to May 16, 1965) Dr. Frank J. Hughes of Camden as the Society's 7th delegate to the AMA; unanimously elected (to May 16, 1965) Dr. Jerome G. Kaufman of Maplewood as the alternate-delegate to fill the vacancy created by the resignation of Doctor Hughes; unanimously elected (to May 16, 1965) Dr. Matthew E. Boylan of Jersey City as the 7th alternate-delegate.

AMA Dues Increase . . . Unanimously instructed the delegates to the AMA to oppose any increase in AMA dues which may be proposed at the February meeting of the AMA House of Delegates.

Regional Planning . . . Voted a one-time contribution of $5,000 to the Health Facilities Planning Council of New Jersey, recognizing that the Society must contribute a fair share toward the operating costs of this voluntary program if it wishes to have a voice in the deliberations of the council and to encourage survival of the program.

Mental Health Conference . . . Authorized Dr. Robert S. Garber of Trenton to be the Society's representative at the AMA Conference of State Mental Health Representatives, to be held in Chicago this month.

AMA Officers . . . Unanimously adopted the recommendation that the President and President-elect of the American Medical Association be invited to attend the 1965 Annual Meeting of MSNJ, as guests and at the expense of the Society.

New Jersey Welfare Council . . . Named Dr. John J. Bedrick of Bayonne as the Society's

representative to participate in planning meetings of the 1965 Annual Conference of the New Jersey Welfare Council, to be held in Asbury Park October 26 through 28.

Medical Education Congress . . . Determined that no official representative from MSNJ will attend the AMA Congress on Medical Education to be held in Chicago this February. (Two members of the Society will, however, be attending as the representatives of the New Jersey State Board of Medical Examiners.)

Medical Education Conference . . . Named Dr. Sherman Garrison, chairman of the Society's Committee on Medical Education, to represent MSNJ at the AMA Conference of State Chairmen of Committees on Medical Education, to be held in Chicago February 6.

Today's Health . . . Authorized to the Woman's Auxiliary an expenditure of $116 for 58 subscriptions to *Today's Health,* to be provided to major colleges and universities in New Jersey—in cooperation with an auxiliary project at national level.

Resolution on Alcoholism

The following resolution was adopted by the Bergen County Medical Society on December 8, 1964.

Whereas, chronic alcoholism is on the rise in Bergen County as well as in New Jersey and ranks among the four major health threats in our nation, along with heart disease, cancer, and mental illness; and

Whereas, organized medicine—which recognizes the disease concept of chronic alcoholism —must be in the forefront of the universally accepted diverse approaches in the prevention, treatment, and rehabilitation of the chronic alcoholic; now therefore be it

Resolved, that the Bergen County Medical Society—which recognizes chronic alcoholism as a progressive, destructive, pathologic condition affecting a great segment of our population—must assume responsibility and take active leadership in fostering an awareness of this condition and in leading a comprehensive constructive rehabilitation program in our own community; and

Be it further Resolved, that copies of this resolution be sent to our New Jersey component medical societies with the hope that a statewide program will be initiated.

Coverage for Slander, Libel, and Defamation

At the request of our Medical Defense and Insurance Committee, and with the approval of our Board of Trustees, the following information on punitive damages and related matters is published for your information. It comes from a letter to Dr. Featherston by the Manager of the Orange (N.J.) Office of the American Mutual Liability Insurance Company.

To my knowledge, American Mutual is the only insurance company with a professional liability policy defining injury to include libel, slander, and defamation of character. This was made part of our contract at the request of your committee.

In a recent lawsuit against over forty doctors in New Jersey who were insured by several insurance companies, the complaint demanded compensatory damages and *punitive damages.* Compensatory damages are to compensate the plaintiff for loss of money, income, pain and suffering as appearing in most liability lawsuits. *Punitive damages* would be an award (in addition to compensatory damages) to *penalize* the defendant for injury due to an *intentional* act or one with *malice.*

Some of the companies stated the doctor was *not covered for punitive damages* and would be directly responsible for such an award. An article in *Medical Economics* several months ago contained the statement no insurance company would cover punitive damages.

The American Mutual, under the professional liability insurance policy issued to members of The Medical Society of New Jersey, in interpreting the word "damages," covers all legal damages which the insured becomes obligated to pay which would include punitive as well as compensatory damages.

—J. A. Britton
Manager

ANNOUNCEMENTS

Pulmonary Heart Disease

Reserve the afternoon of Wednesday, March 31, for a colloquium on pulmonary heart disease. Under the auspices of the New Jersey Heart Association, this seminar will be held at the Robert Treat Hotel in Newark. There is ample parking space in the garage under the Military Park, just across the street from the hotel. The speakers are C. R. Rabin, M.D., H. A. Bickerman, M.D., and Robert E. Forster, M.D.—an unusual trio of distinguished experts in the field. You are invited. The program starts at 2:00 p.m. More details are available from the New Jersey Heart Association at 60 Park Place, Newark.

Medicine in Sports

Any member of our Society interested in the medical aspects of sports, athletics, and recreation may obtain gratis copies of the useful little newsletter called *Medicine in Sports* by writing to the Sports Editor (Mr. Charles Stanton) of the Rystan Corporation, 7 McQuestan Parkway, Mount Vernon, New York.

A Physical Fitness Clinic

You are encouraged to attend a unique "physical fitness" clinic on Friday, March 26, at Harrisburg, Pennsylvania. The morning session will be held in the State Education Building (in the Forum of the State Department of Instruction) beginning at 9:30 a.m. The afternoon program (2:15 to 4:30 p.m.) will be at the Cedar Cliff High School in nearby Camp Hill, Pennsylvania. Featured will be lectures, conferences, actual demonstrations, films, discussions, and the like. The aim of the program is to show how to increase the fitness of youth and adults. For more information, write to the Commissioner of Public Instruction, State Department of Instruction, Harrisburg, Pennsylvania.

Cancer Symposium in Philadelphia

On Wednesday, June 16, 1965, an all-day symposium will be held on hormones and chemotherapy for cancer. Sponsored by the American Cancer Society, the colloquium will be at the Drake Hotel in Philadelphia, starting at 9:00 a.m. For more details, write to Director of Professional Education, American Cancer Society, 219 East 42 Street, New York, New York 10017.

Medical Seminar in Baltimore

A unique medical meeting is announced for the Alcazar in Baltimore. The days are April 21 through 23; Wednesday afternoon to Friday noon. Sponsored by the "Medical and Chirurgical Faculty of Medicine" (which is what the Maryland State Medical Society calls itself), the topics include the population explosion, the management of pulmonary embolism, hypopituitarim, hepatitis, cardiology in the aged, the treatment of hypertension, urology in general practice, the rheumatoid hand, carcinoma of the cervix, and that now fashionable, new-old disease, gout. For a more detailed program, write to Dr. R. T. Shackelford, Medical & Chirurgical Faculty, 1211 Cathedral Street, Baltimore, Maryland 21201.

Medical Lectures on Shipboard This October

The New York Academy of General Practice is sponsoring a 12-day cruise to the West Indies leaving New York on October 15, 1965. The speakers, all from the University of Pennsylvania Medical School, will give courses in virology and endocrinology. Classes will be held on board the Swedish-America liner *Gripsholm*, which will call at the Virgin Islands, Martinique, Barbados, Trinidad, and Puerto Rico, docking in New York harbor on Monday morning, October 25. Rates (includ-

ing meals, room, and tuition fees) begin at $370 and range up to $785 per person. For more details, write to Seymour Fiske, M.D. at 150 East 71 Street, New York City.

Doctor Heads First County College Board

Charles Cunningham, jr., M.D., a member of our Cumberland County Medical Society, became the chairman of Cumberland County College at its organization meeting on January 29, 1965. Dr. Cunningham, a Vineland General Practitioner, is on the staff of the Newcomb Hospital.

Graduate Courses in Philadelphia

Hahnemann announces the following 1965 courses in Philadelphia. For details, write to the Director of Graduate Education at the Hahnemann Medical College, 230 North Broad Street, Philadelphia 2.

April 26, 27, 28 and 29: Cardiac Arrhythmias
July 26, 27, 28, 29 and 30: Cardiac Arrhythmias
November 22, 23, 24: Cancer Chemotherapy
December 8, 9, 10: Gynecologic Oncology.

Colloquium On Childhood Diabetes

Hunterdon County is at its best in spring-time. So here's a chance to visit the trail-blazing Hunterdon County Medical Center on Wednesday, April 28, for an afternoon seminar on childhood diabetes. Dr. Laurence Fineberg (Professor of Pediatrics at Albert Einstein) will talk on diabetic acidosis in children. This will be followed by a discussion of emotional aspects of diabetes, by C. R. Swift, M.D., director of the Mercer County Child Guidance Clinic. Then Dr. Waldo Nelson (Professor of Pediatrics at Woman's Medical College) will review the management of diabetes in children. This program is under the joint sponsorship of our State Health Department and the N.J. Diabetes Association. For details, write to Dr. Arthur Krosnick, Division of Chronic Illness, State Health Department, Box 1540, Trenton 08625.

Physicians' Aid-Carlson Fund

The Los Angeles County Medical Association is sponsoring the collection of a special fund to aid the almost penniless widow and two children of Dr. Paul Carlson, the medical man martyred in the Congo—to which he went in the face of danger and in fulfillment of his oath. Contributions are sent to Physicians' Aid-Carlson Fund at 1234 North Vermont Street, Los Angeles 29, California.

Services For Your Cardiac Patients

Many practitioners do not realize the many services now available to those of your cardiac patients who need financial assistance. Dr. W. Austin Tansey, chairman of our Rehabilitation Committee, summarizes these services below. Financed by the State, the services are made available through the Rehabilitation Commission at 309 Washington Street in Newark. For details, telephone MItchel 8-3445, or call the Heart Association at ORange 7-0880. (For both, the Area Code is 201.)

1. *Counseling.* When application for assistance is made to the Commission, a counselor will be assigned. He will be the one to contact regarding progress of the case.

2. *Diagnostic Service.* In appropriate instances, a patient may be referred to the work Evaluation Unit at St. Michael Hospital for study and classification.

3. *Restoration.* All phases of appropriate therapy are provided.

4. *Training.* The patient may be retrained in his original skill or may be taught a new skill. Established trade schools will be utilized; tuition and other expenses will be provided.

5. *Placement.* Under the direction of the Counselor, the patient will be returned to the level of employment which has been determined by the earlier steps in this program.

Those below age twenty-one may receive benefits, if application is made to the Crippled Children Program, State Department of Health, 211 East State Street, Trenton. Those between ages sixteen and twenty-one may be eligible for benefits in paragraphs 1, 2, 4, and 5, if additional application is made to the Rehabilitation Commission.

BOOK REVIEWS

So Fair a House: The Story of Synanon. By Daniel Casriel, M.D. Englewood Cliffs, N.J., 1963, Prentice Hall. Pp. 224. ($4.95)

The name belongs in your lexicon. Now that Synanon's* five-year record has been authenticated and evaluated by Dr. Casriel, we should be in for a fast and furious medical tennis-match over the pros and cons of this experiment in the group dynamics of rehabilitating drug addicts.

The movement, Dr. Casriel tells us, marks "a major breakthrough in the treatment of drug addiction . . . *far above* anything that medicine, psychiatry, the law, or society can offer . . ." Under Synanon's group process, addicts show "a basic personality structure change which, in a majority of cases, will eliminate the need for the regressive, maladaptive defense of addiction." Dr. Casriel believes that this program offers "a treatment approach to all types of acting-out character disorders . . . capable of reaching so many people as to have a meaningful impact on the country as a whole."

In reporting Synanon's methods, Dr. Casriel comes off rather less well than he does statistically; describing group interaction is like trying to define what makes a party "go." The addict who comes to the Santa Monica beach house, according to Charles E. "Chuck" Diedrich, former alcoholic and its founder and father figure, becomes part of a community composed almost completely of other addicts and "based on primitive tribal structure—with overtones of a 19th century family set-up of the type which produced inner-directed personalities." (A curious analogy, this, when one considers a Dickens papa like Mr. Dombey, or his multitude of characters who seem all too dependent on constant sips of small beer!) First the addict kicks his habit "cold turkey." He does this with far fewer dramatics than usual, in Synanon's knowing environment. Then he starts at the bottom of a ladder which offers him a series of status improvements as he grows emotionally and his drug-free days pile up. He participates at least three times weekly in seminars, "synanons"—where he's verbally savaged by Chuck and other members until he shucks, in open confessions, his immaturity, egocentricity and rigidity of thinking (three earmarks of all addictive personalities, as Dr. Casriel correctly points out). He comes and goes at will, but if he *will* shoot heroin, he finds getting back into Synanon far harder than getting out.

Dr. Casriel is convinced that he has hold of a good hefty rope by which the addict may haul himself up from the sordid morass of his addiction. Yet he seems sometimes to be grasping at straws. Do Synanon's addicts stay clean because of its therapeutic dynamics—or simply because those who are ready to stop at last have a serviceable place to stay? Without the Messianic "Chuck" to impose his monolithic concepts, will other Synanons succeed as brilliantly as the beach house at Santa Monica? Does the verbal brutality of the seminars change the basic personality structure—or does a desperately hopeful personality evolve despite them and because of a generally accepting environment? Dr. Casriel says a personal visit will inevitably end all skepticism and disbelief. How near are you to Santa Monica? San Diego? Reno? Westport, Connecticut?

ELLEN MCCOOLE

Diseases of the Skin. By George Clinton Andrews, M.D. and Anthony N. Domonkos, M.D. Ed. 5. Philadelphia, 1963, Saunders. Pp. 749. 605 illustrations. ($16.50)

The newest edition of this standard text has been thoroughly and carefully revised and is very much up to date. The scope is comprehensive, and the style clear and lucid, making the book equally useful to the practicing physician as a reference and to the student at the graduate level as a teaching text. The aspiring board candidate will find this edition particularly helpful. Current dermatologic thought reflects advances being made in the basic scientific background of the specialty, and this has influenced the authors. Recent concepts are discussed, such as the auto-immune reaction with its possible implication in certain of the collagen diseases, the genodermatoses, cellular and enzyme chemistry, and, of course, therapeutics. Therapy is timely and practical. The newer drugs are discussed, including micronized griseofulvin, folic acid antagonists for psoriasis, the anti-malarials, and the uses and hazards of cortico-steroids, internally, locally, and intralesionally. The sections on drug sensitivity and drug reactions have been correspondingly modernized.

The new format is easy to read with its double columned pages. This permits a better layout for the illustrations, 265 of which are new. A double page spread, as in an atlas, many times reveals several aspects of a disorder for easy comparison. The added illustrations are of high quality. A detailed index is an integral part of the book, and includes symptoms, differential diagnoses, and laboratory findings. The references are carefully selected.

SAMUEL D. KAPLAN, M.D.

Cancer of the Colon, Rectum and Anal Canal. By Harry E. Bacon, M.D. Philadelphia, 1964, J. B. Lippincott Company. Pp. 956; 343, illustrations. ($30.00)

Rarely is a comprehensive treatise published which seems at first reading to be destined to become a classic manual. This book reviews Dr. Bacon's experience over a 22-year period in handling 2,000 cases of cancer of the colon, rectum and anal canal. It furnishes a masterly coverage of all pertinent data and theories contained in the vast literature on the subject, and evaluates them objectively. The bibliographies in each chapter make unnecessary any further search of the literature up to the time of publication of this scholarly monograph.

The author feels that an examination of persons over 35 years old, biannually (digital, sigmoidoscopic, and radiologic), using the double-contrast technic, would triple the present 25 per cent five-year cancer-free survival rate. Nuguid's work on adenomatous polyps of the colon and rectum discusses their relationship to carcinoma; the benign and potentially malignant growths are still a controversial subject.

The indications for and management of colostomy and ileostomy, the prophylactic and surgical treatment of Peutz-Jagher's syndrome, the thorough handling of complications that arise from surgical treatment of lesions of the large bowel, all make impressive reading. The same is true of indications and methods of palliative treatment of patients with inoperable cancer. Anaylsis is made of the various methods used in management of the primary tumor, and prevention of

*Only drug addicts are capable of being this cool: the name of their lifeline, Synanon, is based on a joke—the malapropism committed on "seminar" by an early inmate.

spread of malignant cells, recognition of inherent complications, the proper preoperative and postoperative care, the results obtained from resection of recurrent cases, and the salvaging of certain cases are all thoroughly described. The prognostic importance of findings at the time of surgery is stressed.

The authoritative chapters by well-known specialists are of particular interest: radiation as related to diagnosis and therapy by Robbins and Southard, and anesthesiology by Meschter. Credit is due the publishers for preparation of this large book, with its many tables and figures. Illustrations are clear and detailed, and the legends concise and easily understandable. The art work of Tetsuo Yajuma of the University of Shiba, Japan, gives a colorful and interesting international touch.

This exhaustive work will be a valuable source book in every medical library and hospital, and probably in the office of every proctologist. It is also a valuable reference volume for all doctors interested in the colon, rectum, and anal canal; and for the general practitioner who sees the patient first and seeks a better understanding of early diagnosis and management, and the indications for nonsurgical treatment of these neoplasms. GEORGE L. BECKER, M.D.

A Doctor Talks to 9-to-12 Year Olds. By Marion O. Lerrigo, Ph.D. in consultation with Michael A. Cassidy, M.D. Illinois, 1964, Budlong Press Company. Pp. 75, illustrated. ($1.50)

This is a commendable book in that it is written in so encompassing a fashion. There is no direct implication that it is designed for the purpose of sex education. It appears to be a treatise on family life and living, and within this important framework is explained the necessary function of family procreation. In an era when there seems to be an overemphasis on sexual matters, I find this a refreshing introduction of the subject to young minds. Sex instruction is properly placed in its true perspective—as part of the whole—not the be-it-all of existence, as so-often presented. The book is highly informative. Every part of the reproductive system is properly identified and named in anatomic terms. Here, though, I think the subject is belabored. I doubt that 9-to-12 year olds are quite that discerning about X and Y chromosomes and the tracings of heredity and what path the sperm travels to puncture the egg, etc.

My only reservation about the book has to do with the suggested age for presenting it to the child. As the mother of five girls (ages 19, 17, 15, 9, and 7), I have had much opportunity over the years to meet and observe many youngsters in this age category. And a thorough search of conscience fails to pinpoint any one whom I would consider sufficiently precocious to read and digest this booklet. But herein lies its saving grace. The facts are clearly detailed, and the matter of presentation is left to the discretion of the parent, since no two children develop or mature at the same age—not even within the same family.

For the most part, my own experience and judgment convince me that most 9-to-12 year olds would not wish or hope to deal in such detail about this subject. I believe they want basic questions answered, but to be as thorough and technical as this book is would weary the reader beyond his desire to pursue the contents in its entirety. Eighth graders or highschoolers, yes; but 9-to-12 year olds, no! HELEN G. FOLEY

Trends in Mental Health Services. By Hugh Freeman, M.D. and James Farndale, Ph.D. New York, 1963, Macmillan. Pp. 341. (Price not stated)

Thirty-eight authorities (23 of them physicians), most of them British, here discuss community aspects of psychiatry. As the editors see it, the principal change in community psychiatry—at least in Britain—has been the shift of emphasis from protection (of people and property) to vigorous treatment. There is, in this anthology, a good deal of emphasis on substitutes for the large public mental hospital. Considered are day hospitals, boarding homes, psychiatric services in general hospitals, outpatient departments, community mental health centers, and so on. But the large mental hospital has some defenders, too. There is here much thought-provoking material on coordination between hospital staffs and family doctors; on the relative roles of the general hospital and the mental hospital; on preventing apathy of staff and deterioration of patients in large mental hospitals; on administration; on the services needed for the mentally retarded; on psychiatric nursing; on geriatric problems; on industrial therapy; and on day hospitals. Some contributors have views diametrically opposite those expressed by others—a difference which makes for interesting reading and which helps give a three-dimensional prospective to this unique volume. Although the collection has a strong British accent, the problems and proposed solutions are as applicable on the Atlantic's west shore as on its northeast corner. ABRAHAM LEFF, M.D.

Mama Made Minks. Sara Sandberg. New York, 1964, Doubleday. Pp. 182. ($3.95)

We have, perhaps, been surfeited by accounts of unhappy childhood. It is, therefore, refreshing to get a story of a childhood that could bask in the warmth of an affectionate family where nobody was really mad at anybody, where there were no unconscious hatred, subconscious conflicts, or concealed but evil motives. This is a fragment in the life of a family in the then Jewish middle-class ghetto of Harlem. In bubbling, sometimes poignant fashion, it recalls the joys, sorrows, and problems of New York life just before and after World War I. The author, Sara Sandberg, is the wife of Dr. Frank Rosen, editor of our Essex County Medical Society *Bulletin*. Of medical interest is Miss Sandberg's account of her bout with poliomyelitis and her subsequent experience with Dr. Lorenz. And in these days of questing the feminine mystique, it is pleasant to get an account of a mother and wife who can also be an intellectual. This is a happy book, and one is sorry to come to the last page so soon.
HENRY A. DAVIDSON, M.D.

Man and His Future. Edited by Gordon Wolstenholme. Boston, 1963, Little Brown. Pp. 408 with 8 illustrations. ($6.00)

Most Ciba Foundation symposia deal with deeply technical phases of medical research. This one contains talks and comments from an extraordinary colloquium held in Britain in 1963. Papers were given by 27 distinguished scientists—Brock Chisholm, J.B.S. Haldane, Sir Julian Huxley, and others equally prominent in their several fields. Sociologic, ethical, biologic, physiologic, and economic aspects of the future are all discussed. Most of the authors write with clarity, some with humor, many with wit, all with sense. The role of machines in the future is discussed; population growth; eugenics; diet; agricultural resources; and even the outlook for better brains. The reader is bound to be stimulated by these chapters, unless he is depressed by the thought that maybe mankind has no future. ULYSSES M. FRANK, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

MARCH, 1965 • VOL. XXXVIII, NO. 3

HEPATIC HYDROTHORAX

In a study of a patient with hepatic cirrhosis and pleural effusion, passage of fluid from the peritoneal to the pleural space was traced with serum albumin tagged with I^{131} The diaphragmatic lymphatics appeared to be the route. Twelve other cases are also discussed.

The association of hydrothorax with hepatic cirrhosis has been recognized for many years. There is little doubt that hydrothorax can occur with cirrhosis in the absence of manifest chest disease. In most cases reported, ascites was also present. It has been postulated that the transport of ascitic fluid through the lymphatics into the pleural space accounts for at least some of the hydrothorax.

After a detailed study of a case of hepatic hydrothorax, the charts of 200 consecutive cases of hepatic cirrhosis were studied to find the cases with pleural effusion. Twelve, or 6 per cent, were considered to have hepatic hydrothorax when other causes of pleural effusion could be reasonably excluded. The effusion occurred on the right side in 8, bilaterally in 2, and on the left side in 2.

Special Studies on Case 1

Analysis of the peritoneal and pleural fluids in Case 1 showed that they were similar in most respects. Both met the criteria for transudates, with total protein less than 3 grams per 100 milliliters. The total protein was slightly higher in the pleural fluid due to a larger albumin fraction.

Smears prepared from pleural fluid after intraperitoneal injection of India ink showed macrophages containing many carbon particles. Such particles could not be seen in smears of blood obtained at the same time. After intrapleural injection of the ink, there was no comparable increase in carbon particles in the peritoneal fluid macrophages. Samples of peritoneal fluid obtained before and after the intrapleural ink injection had the same optical densities, supporting the impression that no transfer of carbon took place.

Radioactivity Measured

When radioiodinated serum albumin was injected intravenously in Case 1, radioactivity appeared more rapidly and in greater concentration in peritoneal fluid than in pleural fluid. When similar material was injected intraperitoneally, radioactivity appeared in the pleural fluid and plasma at about the same time and in the same concentration. At 25 hours, the radioactivity per gram of albumin in plasma and pleural fluid was nearly identical, in contrast to results of intravenous study, where at 25 hours the plasma radioactivity per gram of albumin was nearly five times that of pleural fluid. These results suggest that radioactive iodine-tagged albumin was entering the right pleural space directly from the peritoneal space.

After injection of radioiodinated serum albumin into the right pleural space, radioactivity appeared more rapidly and in higher concentration in the plasma than in the peritoneal fluid. At 25 hours, radioactivity per gram of albumin in plasma was 4.9 times that in the peritoneal fluid. This suggests that radioactivity was transported to the peritoneal space via plasma, and there was no direct

ROBERT F. JOHNSTON, M.D., and RODOLFO V. LOO, M.D.; *Annals of Internal Medicine,* September, 1964.

passage of tagged albumin from the pleural to the peritoneal space.

The source of chest fluid found in association with cirrhosis is unknown. It has been suggested that the fluid may come from the blood stream as a result of hypoalbuminemia or hypertension in the azygous and hemiazygous systems or be secondary to ascites either by direct passage of the fluid through a diaphragmatic defect or by transport of ascitic fluid into the pleural space through the diaphragmatic lymphatics.

Ascites Usually Present

Hypoalbuminemia as a sole cause can be eliminated for there are many cirrhotic patients and persons with malabsorption syndromes who have low serum albumin levels but never develop hydrothorax. Of the 200 cases of cirrhosis reviewed, serum albumin levels were obtained in 179. There was a significant difference between the mean serum albumin levels for those cirrhotic patients without ascites and the two other groups composed of patients with ascites alone and with both ascites and hydrothorax. There was no significant difference between the groups with just ascites and the group with ascites and hydrothorax.

Although it seems clear that hypoalbuminemia and azygous hypertension play some role in the etiology of hepatic hydrothorax, these factors alone cannot explain all cases.

The more probable explanation is that hydrothorax is derived directly from the peritoneal fluid. Ascites is present in nearly all cases of cirrhosis when hydrothorax is recognized. All 13 of the cases in this series had ascites, and though there have been reports of hepatic hydrothorax occurring in the absence of ascites, these are rare. It would appear that ascitic fluid passes into the pleural space either through a defect in the diaphragm or via the lymphatic channels that penetrate it.

Data from the present study, suggesting that hydrothorax was not formed exclusively from plasma or as the result of a diaphragmatic defect, are compatible with the theory that chest fluid is the result of transdiaphragmatic transport of ascitic fluid by the lymphatics.

If it is correct that hepatic hydrothorax is secondary to transdiaphragmatic transport of ascitic fluid in the lymphatics, the question must be answered why hydrothorax does not occur in all patients with ascites. Pleural effusion will not be manifest until the rate of formation of pleural fluid exceeds the rate of fluid absorption from the pleural space.

Even in normal man it is likely that pleural fluid is being constantly formed, but an equal rate of absorption prevents accumulation of fluid. In the presence of ascites, the rate of pleural fluid formation appears to be greater than normal. If, in addition, hypoalbuminemia is present, the rate of re-absorption of water from the pleural space will be decreased. If the rate of formation exceeds the rate of absorption, hydrothorax will occur. The probability it will occur will be increased if there are local factors such as azygous hypertension which impedes the absorption of water or obstruction or increased pressure in the thoracic lymphatics which reduces protein absorption.

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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

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1 Nathan, L. A.: Exhibit presented at Mich. Acad. Gen. Pract., Detroit, Mich., Nov. 10

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
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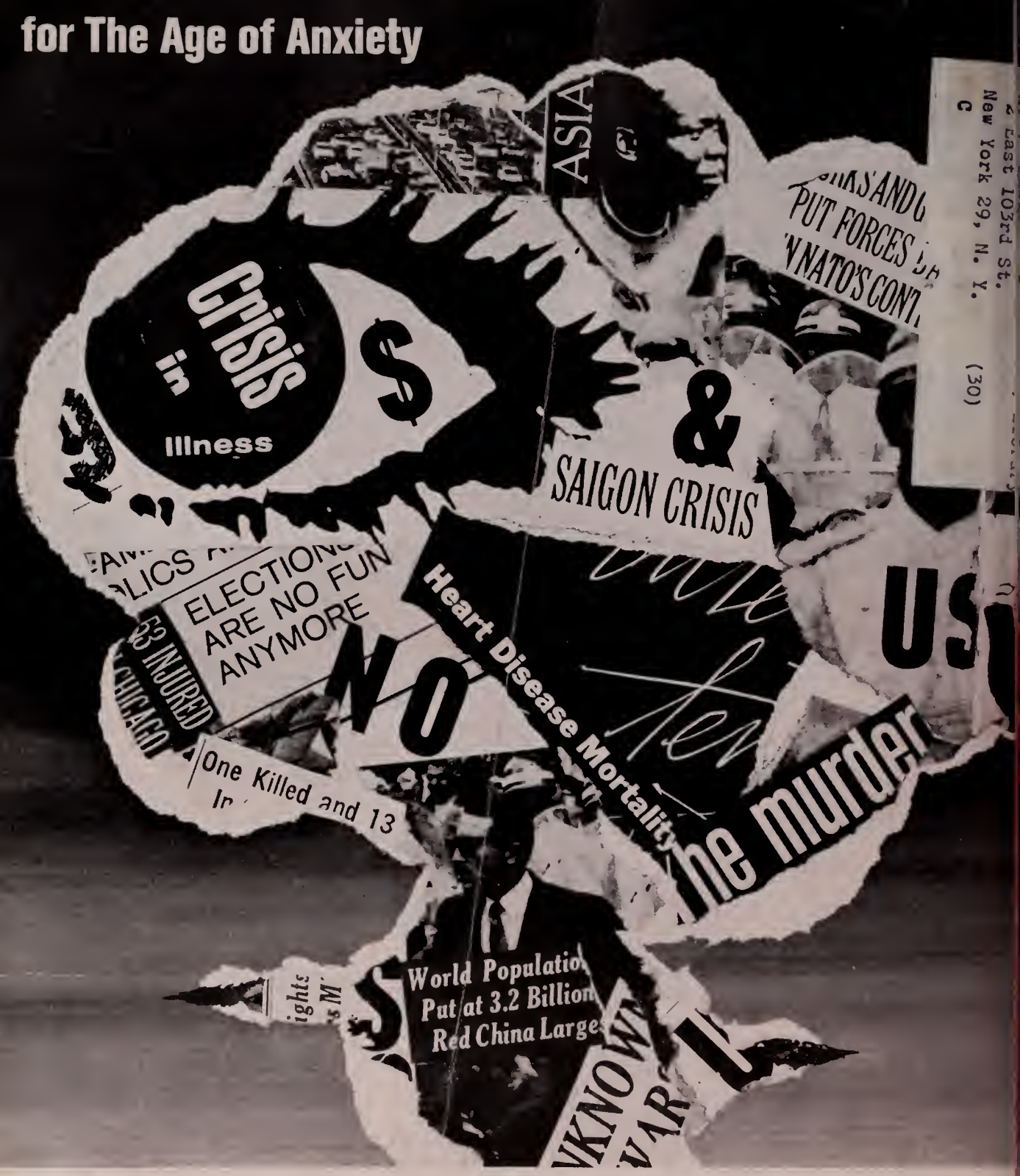
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APRIL, 1965 Vol. 62, No. 4

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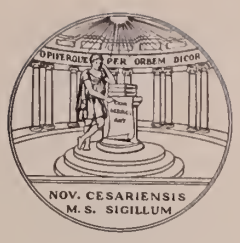
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We would be happy to have you or your patients visit Emery Manor at any time. We are less than 45 minutes from Newark and less than an hour from New York. Coming south you take exit 120 on the Garden State Parkway and follow to Route #34. We are located one mile north of Main Street—Matawan. Our rates are well in line with comparable nursing homes in the area.

EMERY MANOR

Box 61, Matawan, New Jersey. On Route #34 Phone: 566-6400



on, I'll walk you in.



That a smug gleam in your eye?



Could be. My problem hypertensive finally came around.



nant?



No, plain stubborn. Moderately severe. Grade II.



Use anything special?



Regroton. One tablet daily.



Regroton? Haven't tried it yet.



You're missing something.

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Superior to other antihypertensives in 76 of 80 patients in a 2-year study*

Geigy

sition: Each tablet contains chlorthalidone, and reserpine, 0.25 mg.
ndications: History of mental depression, ensitivity, and most cases of severe renal atic diseases.
g: Discontinue 2 weeks before general esia, 1 week before electroshock therapy, depression or peptic ulcer occurs.
tions: Reduce dosage of concomitant anti-ensive agents by one-half. Discontinue if N rises or liver dysfunction is aggravated. lyte imbalance and potassium depletion cur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Average Dosage: One tablet daily with breakfast.
Availability: Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York
RE-3454



WHO NEEDS A BLOOD-GLUCOSE DETERMINATION?

Many of your patients, Doctor. With **DEXTROSTIX®** Reagent Strips, estimating blood glucose takes only 60 seconds. The test can be used for screening in every physical examination and emergency situation. **DEXTROSTIX** is also useful for checking blood glucose in pregnancy, obesity, peripheral vascular disease, certain endocrine disorders, patients on "thiazides" and other potentially hyperglycemic drugs, diabetic screening and management, and other conditions where hypo- or hyperglycemia may be of clinical significance. ☐ Ames Company, Inc., Elkhart, Indiana

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AMES

AMES



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.





Rx for comfort...

ELECTRIC HEAT

Modern Electric Heat offers some special advantages for doctor's offices. First, you get room by room temperature control —a thermostat in each room. This lets you keep your office at one temperature, the waiting room at another. And, if your office is in your own home, there are times you may want to heat your office but not the entire house. Only Electric heat gives you this kind of economical flexibility. Also, if you are adding on to your present offices or home Electric Heat is easy to install, and doesn't require the extension of ugly pipes and radiators. For luxurious cold weather comfort, install modern Electric Heat. Get all the details from your local Public Service office.

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Taxpaying Servant of a Great State

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TUBERCULIN, TINE TEST

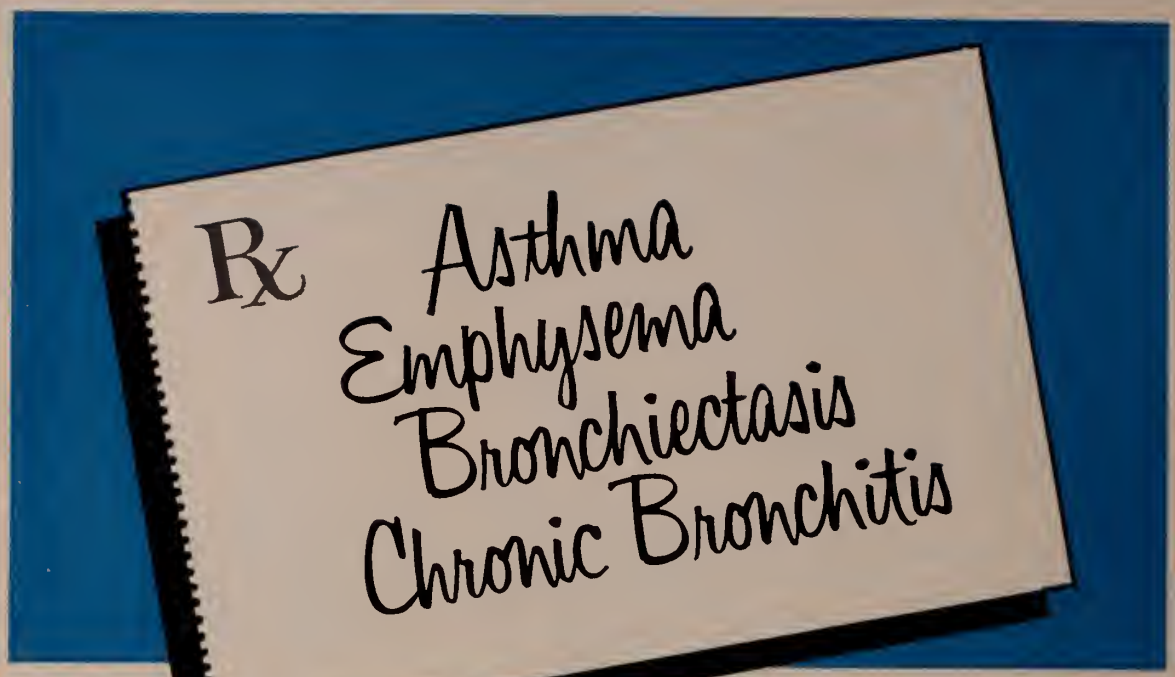
(Rosenthal) Lederle

ideally suited for routine TB screening

accurate—comparable to the older standard intradermal tests
practical—can be administered by nurses or other personnel
convenient—no refrigeration or other storage precautions
economical—stable for 2 years, self-contained disposable unit

Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. *Available* as the new individually-capped unit, boxes of 5, or in cartons of 25.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
9635-5



mudrane®

The Bronchodilator with the intermediate dose of KI

The fast-disintegrating, uncoated tablet gives relief to the asthmatic in 15 minutes. The ephedrine-phenobarbital balance eliminates nervousness. It relaxes broncho-constriction, liquefies mucus-plugging and is buffered for tolerance.

Each tablet contains Aminophylline 130 mg., Ephedrine HCl 16 mg., Phenobarbital 22 mg. (Warning: may be habit-forming), Potassium Iodide 195 mg. Dosage: One tablet, 3 or 4 times a day. Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, and very long use may cause goiter. Iodide contraindications: tuberculosis, pregnancy. Issued in 100's, 1000's.

Also available as

mudrane® GG

Formula is identical to Mudrane except that Glyceryl Guaiacolate 100 mg. replaces the Potassium Iodide as the mucolytic expectorant. Issued in 100's and 1000's.

and

mudrane® GG ELIXIR

The formula of four teaspoonfuls Elixir equals one Mudrane GG tablet. Dosage 6 to 12 years: One to two teaspoonfuls 3 or 4 times a day. Under 6 years, adjust dosage according to age. Issued in pints and half gallons.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

After two months of what **Popular Science** described as "the most extensive listening tests ever made by any magazine," a panel of experts chose components for stereo systems in several price categories. The components in the highest rated system were to be the best available no matter what the price.* "Where there was a more expensive component that produced a detectable improvement in sound," stated **Popular Science** authors Gilmore and Luckett, "it was chosen."

AR-3 speakers and the AR turntable were the choices for **Popular Science's** top system.

The **Popular Science** panel was not alone in its findings. Two other magazines — **Bravo!** and **Hi-Fi Tape Systems** — selected components for the best possible stereo system; AR-3 speakers and

THE AR-3's WERE CHOSEN AS BEST.

REPRINTED COURTESY OF POPULAR SCIENCE MONTHLY © 1963 BY POPULAR SCIENCE PUBLISHING COMPANY, INC



wo of **Popular Science's** five-member panel check speakers.

the AR turntable were the choices in each case. **Gentlemen's Quarterly** chose the AR turntable for its top ($3,824) system, but relegated AR-3's to its "medium-cost" ($1,273) system. (The complete lists of selected components, as they appeared in these four magazines, are available on request.)

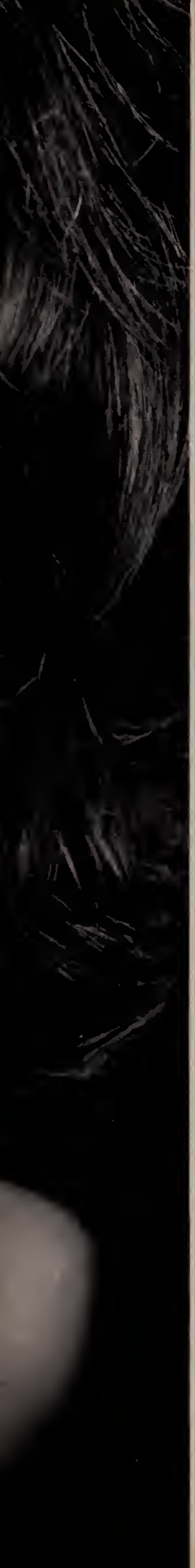
The AR turntable by itself has been reviewed by leading authorities as the best in the entire field regardless of price.

Yet you can spend many times the price of these AR components. AR-3 speakers are $203 to $225 each, depending on finish (other models from $51), and the two-speed AR turntable is $78 including arm, base, and dust cover.

*Speakers limited to "compacts" for reasons of practicality in the home.

ACOUSTIC RESEARCH, INC., ***24 Thorndike Street, Cambridge, Massachusetts 02141***





IF SHE'S JOLTED BY AMPHETAMINE, SWITCH HER TO DESBUTAL GRADUMET

Overweight patients frequently overreact to plain amphetamine, yet fail to respond at all to less potent drugs.

A practical solution is Desbutal Gradumet. Your patient still gets an effective dose of methamphetamine, but overstimulation is prevented by a controlled-release of Nembutal® (pentobarbital). Moreover, the drugs are made available in an effective dosage ratio, minute by minute throughout the day.

Desbutal combines Desoxyn® (methamphetamine) and Nembutal—each in its own matrix, each with its own release rate synchronized to that of the other. The patient isn't upset by quantities of drugs being released at irregular intervals because release is continuous and controlled. There is no reliance on enteric coatings, enzymes, motility or an "ideal" ion concentration. **The only thing the Gradumet needs is contact with fluid.**

Dosage is just once a day.

Precautions: Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or those who are sensitive to ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

DESBUTAL® GRADUMET®

Desbutal 10—10 mg. Methamphetamine, 60 mg. Pentobarbital.
Desbutal 15—15 mg. Methamphetamine, 90 mg. Pentobarbital.
Gradumet—Long-release dose form, Abbott.

ABBOTT

CALMS HER ANXIETIES EVEN AS IT CONTROLS HER COMPULSIVE URGE TO EAT

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disability without debilitation.



supportive oral anabolic therapy • potent • well-tolerated

Disabling illness or injury at any time of life can invite a slowdown in the natural anabolic processes or acceleration of catabolic processes, resulting in a "wasting" of protein and minerals needed for tissue repair. Loss of weight and appetite, strength and vitality, may be the evident signs of this process, frequently accompanied by a lowering of mood, interest and activity. The older the patient, the more pronounced may be the signs of debilitation. A potent, well-tolerated anabolic agent plus a diet high in protein can make a remarkable difference.

WINSTROL® brand of STANOZOLOL

. . . a new oral anabolic agent, combines high anabolic activity with outstanding tolerance. Although its androgenic influence is extremely low*, women and children should be observed for signs of slight virilization (hirsutism, acne or voice change), and young women may experience milder or shorter menstrual periods. These effects are reversible when dosage is decreased or therapy discontinued. Patients with impaired cardiac or renal function should be observed because of the possibility of sodium and water retention. Liver function tests may reveal an increase in BSP retention, particularly in elderly patients, in which case therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage in adults, *usually 1 tablet t.i.d.;* young women, *1 tablet b.i.d.;* children (school age), *up to 1 tablet t.i.d.;* children (pre-school age), ½ *tablet b.i.d. Shows best results when administered with a high protein diet. Available as scored tablets of 2 mg. in bottles of 100.*

*The therapeutic value of anabolic agents depends on the ratio of anabolic potency to androgenic effect. This anabolic-androgenic activity ratio of Winstrol is greater than that of all the oral anabolic agents currently in use.

Winthrop

Winthrop Laboratories, New York, N. Y.

When you put patients on "special" fat diets..

you can assure them that no corn oil margarine is higher in polyunsaturates or lower in saturates than Mrs. Filbert's Corn Oil Margarine.

And once they've tried it, they can tell you that no margarine can match Mrs. Filbert's flavor.

Mrs. Filbert's Corn Oil Margarine is a special margarine* made from 100% corn oil, over 50% of which retains its liquid characteristics.

Of the total fatty acid content 28% is cis-cis linoleic acid. Ratio of polyunsaturates to saturates is about 1.7 to 1.

For additional information, including detailed listings of component characteristics, please write to us: J.H. Filbert, Inc., Baltimore 29, Maryland.



* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

Depend on low-cost, low-dosage Prolixin — once-a-day



Prolixin is a dependable tranquilizer that provides your patient with low cost therapy. No other tranquilizer costs less. Safe and convenient for office use—Prolixin in a single daily dose provides prolonged and sustained action. Markedly low in toxicity and virtually free from usual sedative effects —Prolixin is indicated for patients who must be alert. Clinical experience indicates fluphenazine hydrochloride is especially effective in controlling the symptoms of anxiety and tension complicating somatic disorders such as premenstrual tension, menopause, or hypertension—also useful for anxiety and tension due to environmental or emotional stress. When you prescribe Prolixin you offer your patient effective tranquilization that is low in cost, low in dosage and low in sedative activity.

THE SQUIBB TRANQUILIZER

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SIDE EFFECTS, PRECAUTIONS, CONTRAINDICATIONS: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photo-sensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders.

AVAILABLE: 1 mg. tablets. Bottles of 50 and 500.

For full information, see your Squibb Product Reference or Product Brief.

SQUIBB Squibb Quality—the Priceless Ingredient

SQUIBB DIVISION Olin



BSP® DISPOSABLE UNIT

H.W.&D. BRAND OF SULFOBROMOPHTHALEIN SODIUM INJECTION, U.S.P.

(50 mg. per ml.)

Bromsulphalein (BSP), one of the most sensitive diagnostic agents for evaluating liver function, is now available in a new Disposable Unit. Each "unit" contains: A sterile BSP syringe calibrated in milliliters and pounds (utilizing the 5 mg./kg. BSP dosage schedule), a sterile disposable needle, alcohol swab and a 7.5 or 10 ml. size ampule of BSP.

The precalibrated dosage schedule imprinted on the syringe barrel makes weight calculations unnecessary—saving time and assuring proper administration of the dye, regardless of patient-weight.

Literature on indications and dosage available on request.

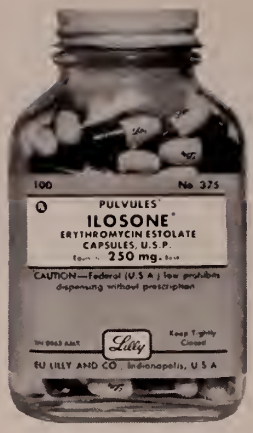
The NEW BSP DISPOSABLE UNIT is supplied in 7.5 and 10 ml. sizes in boxes of 10's and 25's.

HYNSON, WESTCOTT & DUNNING, INC.

(BSP01)

BALTIMORE, MARYLAND 21201

An added margin





to meet an extra challenge

Test-tube activity of a drug is only one indication of its effectiveness. More important is the amount of antibacterial activity at the site of infection.

Ilosone® produces peak levels of antibacterial activity *two* to *four* times those of other erythromycin preparations. Furthermore, it attains them earlier and maintains them longer.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Dosage: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules®, suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

Ilosone®
Erythromycin Estolate

Lilly

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis 6, Indiana.

500295

EDITORIAL

Keep That Resolution!

So, you started 1965 with a new resolution: I will keep up to date on medical progress. I will buy and read (from cover to cover) several new medical texts. I will digest each article in the State JOURNAL and in the other medical periodicals. I will go to meetings of my county society and of my hospital staff. I will, I will, I will. . . .

But you didn't. It was easier to glance at the colorful brochure sent by a generous drug company. It was quicker to gulp down the compact little abstracts thoughtfully prepared and carefully pre-digested by an enterprising pharmaceutical manufacturer.

But now is your chance to keep your resolution. Come to our Annual Meeting next month. Hear the papers, cross-examine the authors, see the scientific exhibits,* and quiz the experts. Breathe the bracing saline air, impale your dentures on salt water taffy (which, by the way, contains no salt water, so your hypertensive patients may chew it, too), and greet your classmates (who always seem to age faster than you do). Sit in on the great Parliament of New Jersey Medicine (otherwise known as our House of Delegates) and see how it operates. Appear before reference committees and let them know how you feel. (It's more effective than staff-room griping.)

Everybody goes to Atlantic City. Why not you?

The Rising Tide Of Self-Medication

As doctors, we have always frowned on self-medication by untutored laymen. The reasons are obvious. And since the development of television, the situation has become more distressing, since many TV commercials now show the inside story of how Peregrin's Panacea Pills slide gently down the trachea into the spleen and, in technicolor, chase out the germs and the ulcers.

And now come a number of our distinguished colleagues to suggest that maybe self-medication isn't so bad after all. On November 6 last, the New York Academy of Sciences held a colloquium splendidly called "Home Medication and the Public Welfare." Among those present were Doctors Morris Fishbein, John Krantz, Leroy Burney (former U.S. Surgeon General), Irving Sunshine, and Dr. Herman Hilleboe (formerly New York's Health Commissioner). All of the brethern had good things to say about self-medication. Dr. Sunshine reported that there were fewer mishaps with home medicines than with prescription drugs. Dr. Burney suggested that self-medication satisfies a physical or emotional need, and that it also made "a distinct contribution to the total health resources of the community." Speaking for all of us, Dr. Fishbein assured his audience that "the medical profession recognizes the desirability of self-help . . . and that minor complaints are treated satisfactorily on the basis of long experience." Dr. Fishbein also saw another value in do-it-yourself medicine. "In some foreign countries," he said—naming no names—"physicians are frequently exhausted by the necessity of prescribing for innumerable complaints." Put in that perspective, self-medication was seen as a bulwark of the American system of medical practice. Dr. Arthur Grollman used a proof-of-the-pudding formula and concluded that "the widespread popularity of non-prescription drugs is evidence that they bring relief."

Of course, some of America's orgy of self-medication is due to high pressure television and radio advertising; but some of it is due

* And, by all means, see the commercial exhibits and let the exhibitors know that you've been there. We need them. We were sincere when we referred to the enterprising pharmaceutical manufacturer and the generous drug companies.

to the reluctance of some doctors to make calls on what sound like minor complaints. As a profession, we have to decide whether we should continue to oppose self-medication (and if so whether we should not, in support of our position, be more regularly and swiftly available) or whether we should agree with our forceful colleagues at the Academy of Sciences Symposium and encourage a wider use of the commercially advertised, over-the-counter, self-prescribed proprietaries. Or it may be that Gilbert Weil, the well-known New York attorney, was right when he said that people "have an instinct to medicate themselves" and that we would simply encourage "bootleg use of home remedies" if we continued to insist on the old-fashioned idea that only people who know something about pharmacology should decide which drugs ought to be poured into the human body.

Drug Names On the Rx Label

The latest fashion in democracy in medical practice is to share with the patient the name of the drug. If the doctor prescribes amphetamine, he writes "amphetamine" on the label or instructs the pharmacist to do so. This, it is asserted, makes for better doctor-patient relations (they become buddies, sharing the same knowledge) and also, in the event that the patient is poisoned by the medication, the emergency doctor can just look at the label on the bedside bottle and dash off a prescription for the antidote. Neither of these virtues would seem great enough to warrant a disturbance in the mystique of medicine which would follow when we convert the prescription (once a passport to health) into a simple merchandise order.

Name-labelling makes life easier for the pharmacist, but we see now that the *Professional Pharmacist* (highly respected nationwide journal of that profession) doesn't like the idea, either. Here is an editorial by Irving Rubin, R.P., the editor of that periodical, which appeared in its November 1964 issue.

More and more physicians are requesting that the drug name appear on the prescription label—unless they specify that it should not.

It is *not* advisable automatically to place the drug name on the prescription label. Here are the reasons:

Reason No. 1: The physician arrives at a diagnosis via a complex procedure that earns him the respect of his patients. This complex procedure is *oversimplified* when it is reduced to the name of a drug on a label.

Reason No. 2: Newspapers and magazines are loaded with exaggerated reports on adverse drug reactions and toxicity. These reports mention the names of drugs. For example, if the millions of users of Parnate and their families had read the reports about the drug, they would have become unduly alarmed—if the name had appeared on their Rx labels. The same applies to the millions of Enovid users and their families, when the public press *erroneously* linked the drug to cancer in humans.

Reason No. 3: When a patient knows the name of a drug, he can put pressure on the physician. For example, 2 women—both patients of a drug-name-on-the-label MD—brought in Rxs at about the same time to a pharmacy. One inquired of the other: "What did Dr. X prescribe for you?" Upon hearing the drug name, the inquirer urged: "Don't take it. It did me no good."

Reason No. 4: Even physicians who favor placing the drug name on the label often say that there are exceptions to this rule—conditions under which the drug name should *not* be on the label. When a physician makes such an exception, the patient may say to himself: "I wonder if I have a serious disease, like cancer?" . . . or "Is the doctor giving me a barbiturate or a narcotic?"

Reason No. 5: When a patient knows the name of a drug, it leads to self-medication and to patient-prescribing for others. If the drug happens to be a "prescription only" drug and the pharmacist says that he cannot supply it without specific permission from the doctor, some people suspect physician- pharmacist collusion.

Reason No. 6: Patients who know the names of the drugs will price-shop—by asking for the drug by name. With all the look-alike and sound-alike drug names—coupled with the many forms and dosage strengths—the patient may get the wrong drug or the wrong strength.

To sum up: The physician should retain full control of therapy in the interest of public health. When he specifies that the name of the drug be placed *automatically* on the Rx label, he tends to lose control of that therapy.

There are, we recognize, several rational justifications for placing the name on the label. But in the physician-patient relationship, we sometimes need the irrational components, too.

Saturday-Wednesday
May 15-19, 1965
Haddon Hall, Atlantic City

199th ANNUAL MEETING

The Medical Society of New Jersey

Daily Schedule

Friday, May 14, 1965

5:00 p.m.—Board of Trustees

Saturday, May 15, 1965

10:00 a.m.—Registration Opens

10:30 a.m.—Annual Meeting, New Jersey Trauma Committee

12:30 p.m.—Orthopedic and Surgical Sections, The Academy of Medicine of New Jersey

2:00 p.m.—Golden Merit Award Ceremony
followed by
Reception for Award Recipients and Their Families

4:00 p.m.—House of Delegates
followed by
Open Discussion on Medical-Surgical Plan

6:00 p.m.—Board of Trustees' Dinner (by invitation only)

8:30 p.m.—Nominating Committee

Sunday, May 16, 1965

11:00 a.m.—Reference Committees

2:00 p.m.—House of Delegates (election)

3:00 p.m.—General Session

6:00 p.m.—Essex County Reception (by invitation only)

6:30 p.m.—Reception-Buffet for Technical Exhibitors (by invitation only)

Monday, May 17, 1965

9:00 a.m.—Exhibits Open

Scientific Sessions:

9:00 a.m.—Allergy, Chest Diseases

9:30 a.m.—Obstetrics and Gynecology, Pediatrics, Psychiatry and Neurology
Clinical Pathology, Urology

9:45 a.m.—Otolaryngology

12:00 noon—Luncheon—Section on Rheumatism

12:30 p.m.—Annual Meeting and Luncheon—New Jersey Chapter, American College of Chest Physicians

Scientific Sessions:

2:00 p.m.—Obstetrics and Gynecology, Pediatrics, Psychiatry and Neurology (continued)
Anesthesiology, Cardiovascular Diseases
Medicine
Rheumatism

7:00 p.m.—Annual Dinner-Dance

Tuesday, May 18, 1965

7:00 a.m.—JEMPAC Breakfast Meeting

9:00 a.m.—House of Delegates

Special Scientific Sessions:

9:30 a.m.—Drug Addiction
Perinatal Mortality

1:30 p.m.—House of Delegates Reconvenes

Special Scientific Sessions:

2:00 p.m.—Cancer Chemotherapy
Community Mental Health Centers

5:30 p.m.—Reception Honoring President-Elect Bedrick
All members, official guests, and their wives are cordially invited to attend.

Wednesday, May 19, 1965

9:00 a.m.—Board of Trustees

Scientific Sessions:

9:30 a.m.—Gastroenterology and Proctology, General Practice, Radiology, Surgery
Ophthalmology

9:45 a.m.—Dermatology
Metabolism

12:00 noon—Luncheon—Section on Metabolism

Scientific Sessions:

2:00 p.m.—Gastroenterology and Proctology, General Practice, Radiology, Surgery (continued)
Orthopedic Surgery

3:00 p.m.—Exhibits and Registration Close

House of Delegates

President, Charles H. Calvin, M.D., Perth Amboy
Secretary, Marcus H. Greifinger, M.D., Newark
Parliamentarian, Robert M. Backes, Trenton

Sessions

Saturday Afternoon, May 15, 1965

4:00 p.m.—First Session:

Invocation

The Rev. Canon George H. Boyd, D.D., Rector
St. Peter's Episcopal Church, Perth Amboy

Call to Order

Organization of the House

Transactions of 1964 House of Delegates

Introduction of Guests and Delegates from Other States

Annual and Supplemental Reports

Proposed Amendments to the Constitution and Bylaws

Resolutions

New Business

Announcements

Sunday Afternoon, May 16, 1965

2:00 p.m.—Second Session:

Report of Nominating Committee

Election

Tuesday Morning, May 18, 1965

9:00 a.m.—Third Session:

Reports of Reference Committees

11:30 a.m.—Luncheon Recess

Tuesday Afternoon, May 18, 1965

1:30 p.m.—Third Session Continued:

Reports of Reference Committees

Unfinished Business

Address of the President

Installation of the Incoming President

Inaugural Address

Adjournment

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Dinner-Dance

Monday Evening May 17, 1965
7:00 p.m.

honoring

President and Mrs. Charles H. Calvin

Toastmaster
Richard I. Nevin

Welcome
Mrs. Philip J. Kunderman, President, Woman's Auxiliary

Introductions
Mrs. Lewis C. Fritts, President-Elect, Woman's Auxiliary
John J. Bedrick, M.D., President-Elect

Presentations
Fellow's Key
To: Charles H. Calvin, M.D., President
By: Jerome G. Kaufman, M.D., Immediate Past-President

Fellowette's Pin
To: Mrs. Philip J. Kunderman, President, Woman's Auxiliary
By: Charles H. Calvin, M.D., President

Guest Speaker
"The Doctor's Role in Public Affairs"
Honorable Walter H. Judd, M.D., Washington, D.C.

Music
Martin King and His Orchestra Associates

Golden Merit Award Ceremony

Saturday Afternoon, May 15, 1965
2:00 p.m.

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Presiding
Charles H. Calvin, M.D., President

Master of Ceremonies
John F. Kustrup, M.D., Chairman, Council on Public Relations

Marshals
Presidents of component societies whose members are receiving awards.

followed by

Reception for Award Recipients and Their Families

Reference Committees

Sunday, May 16, 1965
11:00 a.m.

Reference Committee on Constitution and Bylaws

Report of the:
- Committee on Revision of Constitution and Bylaws

Amendment to Bylaws

Reference Committee "A"

Reports of the:
- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Director
- Committee on Credentials

Reference Committee "B"

Reports of the:
- Treasurer
- Committee on Finance and Budget
- Committee on Publication
- Committee on Medical Student Loan Fund

Reference Committee "C"

Reports of the:
- Medical Service Administration
- Medical-Surgical Plan
- Medicare Program

Reference Committee "D"

Reports of the:
- Committee on Medical Defense and Insurance
- Committee on Medical Education
- Committee on Medicine and Religion
- Committee on Retirement Plan for Physicians

Reference Committee "E"

Reports of the:
- Council on Legislation
- Council on Public Relations

Reference Committee "F"

Reports of the:
- Council on Medical Services, and its Special Committees on:
  - Occupational Health
  - Workmen's Compensation

Reference Committee "G"

Reports of the:
- Council on Public Health, and its Special Committees on:
  - Cancer Control
  - Child Health
  - Chronically Ill and the Aging
  - Conservation of Hearing and Speech
  - Conservation of Vision
  - Maternal and Infant Welfare
  - Mental Health
  - Rehabilitation
- Subcommittee on Air Pollution

Reference Committee "H"

Reports of the:
- Committee on Annual Meeting, and its Subcommittees on:
  - Scientific Exhibits
  - Scientific Program
- Committee on Honorary Membership
- Committee on Disaster Medical Care
- Committee on Nursing Education and Recruitment
- Committee on Traffic Safety
- Advisory Committee to the Woman's Auxiliary

Nominations for Emeritus Membership

Scientific Section Officers

Allergy
CHAIRMAN—William I. Weiss, M.D., Livingston
SECRETARY—Maclyn Cagan, M.D., Rahway

Anesthesiology
CHAIRMAN—Bernard C. Kaye, M.D., Long Branch
SECRETARY—Stephen H. Mazur, M.D., Short Hills

Cardiovascular Diseases
CHAIRMAN—Angelo J. Migliori, M.D., Trenton
SECRETARY—Marvin C. Becker, M.D., Millburn

Chest Diseases
CHAIRMAN—Meyer T. Weissman, M.D., Elizabeth
SECRETARY—Mervin G. Olinger, M.D., Verona

Clinical Pathology
CHAIRMAN—Raymond E. Conover, M.D., Belmar
SECRETARY—S. Raymond Gambino, M.D., Englewood

Dermatology
CHAIRMAN—Samuel D. Kaplan, M.D., Elizabeth
SECRETARY—Sam Atkinson, M.D., Morristown

Gastroenterology and Proctology
CHAIRMAN—James Edson, M.D., Paterson
SECRETARY—Abraham I. Friedman, M.D., Hackensack

General Practice
CHAIRMAN—Edward A. Schauer, M.D., Farmingdale
SECRETARY—Gustave L. Ibranyi, M.D., Newark

Medicine
CHAIRMAN—Elmer J. Elias, M.D., Trenton
SECRETARY—Joseph A. Linsk, M.D., Atlantic City

Metabolism
CHAIRMAN—John F. Marshall, M.D., Trenton
SECRETARY—Murray D. Shepp, M.D., Trenton

Obstetrics and Gynecology
CHAIRMAN—Eugene J. Slowinski, M.D., Newark
SECRETARY—Robert E. Sexton, M.D., Point Pleasant

Ophthalmology
CHAIRMAN—Paul H. Pettit, M.D., Ocean City
SECRETARY—Anthony M. Sellitto, M.D., South Orange

Orthopedic Surgery
CHAIRMAN—Daniel M. Winters, M.D., Red Bank
SECRETARY—Robert G. Greene, M.D., Montclair

Otolaryngology
CHAIRMAN—Julio T. Noguera, M.D., Neptune
SECRETARY—Thomas F. Flynn, Jr., M.D., Woodbury

Pediatrics
CHAIRMAN—Seymour F. Kuvin, M.D., Morristown
SECRETARY—Robert Forer, M.D., Trenton

Psychiatry and Neurology
CHAIRMAN—Eugene Revitch, M.D., Plainfield
SECRETARY—Arnold M. Kallen, M.D., Newark

Radiology
CHAIRMAN—Philip D. Gilbert, M.D., Camden
SECRETARY—John W. Marquis, M.D., Chatham

Rheumatism
CHAIRMAN—Lawrence J. Denson, M.D., Hackensack
SECRETARY—Georgia E. Allen, M.D., Haddon Heights

Surgery
CHAIRMAN—C. Buckman Katzenbach, M.D., Flemington
SECRETARY—William E. Philip, M.D., Morristown

Urology
CHAIRMAN—Milton L. Lieberman, M.D., Elizabeth
SECRETARY—Robert L. Lieb, M.D., South Orange

Scientific Sessions

Sections on

Allergy
Chest Diseases

Joint Session

Monday Morning, May 17, 1965

9:00 a.m.

Election of Officers

9:10 a.m.

Symposium — Asthma, Bronchitis, and Emphysema

Moderator

SAMUEL BUKANTZ, M.D., Associate Clinical Professor of Medicine, New York University School of Medicine, New York, N. Y.; Director of Clinical Investigation, Schering Corporation, Bloomfield

Asthma

FRANCIS C. LOWELL, M.D., Assistant Professor of Medicine, Harvard Medical School; Chief of Allergy Unit, Massachusetts General Hospital, Boston, Mass.

Asthma is a form of obstructive pulmonary disease attributable to smooth muscle spasm, edema, increased secretions, and an inflammatory reaction in the wall of the bronchial tree. It is an obstructive allergic bronchitis. The differentiation of asthma from emphysema is of great prognostic and therapeutic importance. The total eosinophile count, simple tests of pulmonary function, and therapy with steroids have been helpful in differential diagnosis between asthma and emphysema and in the management of asthma. These and other aspects of the relevant diagnostic and therapeutic problems are discussed.

Bronchitis

GUSTAVE A. LAURENZI, M.D., Upper Montclair; Associate Professor of Medicine, New Jersey College of Medicine, Jersey City; Assistant Attending Physician, The Mountainside Hospital, Montclair

Emphysema

EDWIN R. LEVINE, M.D., Assistant Professor of Clinical Medicine, The Chicago Medical School; Director of Inhalation Therapy Department, Edgewater Hospital, Chicago, Ill.

11:45 a.m.

Visit to Exhibits

12:30 p.m.

Annual Meeting and Selman Waksman Honorary Luncheon, New Jersey Chapter, American College of Chest Physicians

Reservations: M. T. Weissman, M.D., 853 Park Ave., Elizabeth

Sections on

Clinical Pathology
Urology

Joint Session

Monday Morning, May 17, 1965

9:30 a.m.

Election of Officers

9:40 a.m.

Panel — Diseases of the Prostate

Anatomical and Biological Factors in Prostatic Carcinoma

ANTHONY R. FERNICOLA, M.D., Attending in Urology, St. James Hospital, Newark

The biologic potential of prostatic cancer is unknown. Greater recognition of cytologic, biochemical, and hormonal characteristics of the prostate gland will further integrate the diverse concepts of environment and behavior of prostatic tumor growth. A more definitive classification of anatomic staging of the extent of the prostatic cancer and the pathologic division of tumor types and grades will yield more efficacious therapeutic modalities. In the main, the urologist engages in a biologic truce with the prostatic cancer which he judges clinically to be unamenable to extirpation.

Cytologic Diagnosis in Urology

DONALD J. MacPHERSON, M.D., Livingston; Director of Laboratories, Strang Clinic, New York, N. Y.

Methods of specimen preparation are described. Also reviewed are cytologic diagnostic criteria of malignancy as well as the diagnostic accuracy of tumors arising within the genito-urinary tract, including the prostate. The promise of cytology as a helpful adjunct in urologic practice is explored.

A Modern Approach to the Diagnosis and Management of Carcinoma of the Prostate

WILLIAM A. MILNER, M.D., Clinical Professor and Chairman, Department of Urology, The Albany Medical College, N. Y.

The current method of diagnosis and management of prostatic cancer has been evolved over more than twenty-five years in a clinic where a relatively large number of these cases are seen each year. At the Albany Hospital, 563 cases have been seen during the ten year period ending in June 1964.

The type of therapy employed and the survival rates for the ten year period are discussed. The author expresses his personal philosophy, justifying conservative therapy, for the most part, in the treatment of this disease.

Pathology of Tumors of Prostate

FATHOLLAH K. MOSTOFI, M.D., Armed Forces Institute of Pathology; Clinical Professor of Pathology, Georgetown University Hospital, Washington, D. C.

Round Table Discussion

11:45 a.m.

Visit to Exhibits

Sections on

Obstetrics and Gynecology
Pediatrics
Psychiatry and Neurology

Joint Session

Monday, May 17, 1965

9:30 a.m.

Election of Officers

9:45 a.m.

Symposium — The Brain Damaged Child

Task Force for the Future

MIRIAM SACHS, M.D., Metropoliton District State Heolth Officer, New Jersey Stote Department of Health, Newark

Traditionally, the major focus of responsibility for dealing with mental subnormality has been shared by three disciplines—pediatrics, psychiatry, and neurology. In recent years, emphasis on birth injuries and birth difficulties as a cause of brain damage has added the obstetrician to the team of specialists concerned with the brain damaged child. Now under consideration is a program to be established with federal funds to assist state and local health departments in administering programs of maternal and infant care. In the words of the legislation—"To help reduce the incidence of mental retardation caused by complications associated with child bearing . . ."—grants may be approved for projects which provide ". . . necessary health care to prospective mothers who have or are likely to have conditions associated with childbearing which might impair the health of the mothers or their infants and whom the state or local health agency determines will not receive the necessary health care because they are from low-income families or for other reasons beyond their control."

Standards for prenatal, obstetrical, postpartum, and neonatal care must be agreed upon to qualify for participation in the infant and maternity care projects. The standards are those recommended by the American College of Obstetricians and Gynecologists and by the American Academy of Pediatrics.

Obstetrical Responsibilities and the Brain Damaged Child

MARTIN L. STONE, M.D., Professor and Choirmon, Department of Obstetrics and Gynecology, New York Medical College, New York, N. Y.

Etiology and Prophylaxis of Brain Damage

RICHMOND S. PAINE, M.D., Professor of Pediotric Neurology, The George Woshingtan University School of Medicine; Neurologist, Children's Hospitol of the District of Columbia, Woshington, D. C.

Histories of patients with minimal degrees of brain damage are reviewed with respect to possible etiologic factors in terms of cerebral insults before, during, or subsequent to birth. These circumstances are then compared with the histories of patients with cerebral palsy or other more overt brain damage. The identification of the newborn who has sustained a potential cerebral insult is discussed, together with consideration of prognostic signs and of methods of treatment available to prevent or minimize brain damage.

11:45 a.m.

Visit to Exhibits

2:00 p.m.

Diffuse Brain Damages in Children

LAURETTA BENDER, M.D., Director of Psychiatric Research, Children's Unit, Creedmoor State Hospitol, Queens Villoge, N. Y.

Perinatal brain damage often results in a syndrome in which the child shows maturational lags, poorly differentiated and poorly integrated (plastic) perceptual patterns, a predisposition to anxiety, and a prolongation of infantile behavior. Learning difficulties are more apparent in such children. Childhood schizophrenia, in genetically vulnerable children, may become decompensated. Then the child will present the clinical picture of both the brain damage and schizophrenia. Treatment should include prolonged and intensive "mothering" and special training and therapies to correct the specific disabilities and symptoms. The early lag in maturation and disorganization in personality tend to correct themselves with acceleration before or about the time of puberty.

Diagnosis of Minimal Brain Damage

SUZANNE A. WIDROW, M.D., Assistant Associote, Morristown Memorial Hospital

Identification of the minimally brain damaged is the responsibility and the concern of those involved with children who have learning or behavior problems. At least five percent of the total elementary school population suffers from some form of brain damage. However, this designation does not necessarily imply mental retardation.

A definition of the term "minimal brain damage" is offered to include the various etiologic factors that have been implicated. A particular child may not have all the symptoms attributed to this syndrome, since each child has his own cluster of symptoms. A general review of symptoms and diagnostic procedures is presented.

The Ego Deviant Retardate

BERNARD R. GOLDBERG, M.D., Medicol Director, Guidance Clinic for the Retarded, East Oronge

One of every two retardates, whether brain injured or not, displays on close examination severe defects in autonomous ego functions. Such disturbances (in speech, perception, intelligence, motility, object relations) can best be understood in terms of the interaction between constitutional givens and cultural-emotional deprivations. Brain damage plays a secondary role.

4:15 p.m.

Visit to Exhibits

Section on

Otolaryngology

Monday Morning, May 17, 1965

9:45 a.m.

Election of Officers

10:00 a.m.

Facial Paralysis: Its Treatment by Surgical Decompression

BERNARD J. RONIS, M.D., Professor of Otorhinology, Temple University School of Medicine, Philodelphio, Pa.

Discussor: Aris M. Sophocles, M.D., Trenton

Facial paralysis frequently falls in the realm of the otologist because the nerve is most frequently affected in its course through the temporal bone. Inflammatory disorders of the nerve are usually associated with acute and chronic middle ear and mastoid disease. With the availability of microsurgery for otosclerosis and for chronic otitis media, it is now well recognized that dehiscences of the facial nerve are not uncommon. Involvement of the facial nerve with chronic otitis media is still encountered despite the use of antibiotics. Surgical treatment of facial palsy is assuming greater importance in recent years because of test technics that determine the prognosis for recovery. This information may be a guide for patients requiring surgical decompression. The experience of the otologists in these disorders is reviewed.

10:40 a.m.

Meniere's Disease and Its Surgical Treatment

DAVID AUSTIN, M.D., Chief of Otology Section, Department of Otoloryngology, The University of Illinois College of Medicine, Chicogo, Ill.

Discussor: Wolter A. Petryshyn, M.D., Upper Montcloir

The treatment of Meniere's Disease has, in the past, been concerned chiefly with the alleviation of the incapacitating attacks of vertigo associated with the acute phases of the disease. We now know that the process chiefly affects the cochlear portion of the inner ear. Effective treatment should control or halt this process to preserve or improve hearing in these patients. New forms of conservative surgical management show the promise of obtaining these goals in a high proportion of patients not responding to medical management.

The conservative surgical approach attempts to create a permanent fistula between the endolymphatic sac and the subarachnoid space to relieve the hydropic dilitation of the endolymphatic sac. This simple mastoid procedure has been effective in controlling the disease in 70 to 80 per cent of the subjects. It has been associated with further loss of hearing in 5 per cent. Twenty percent of patients have had hearing improvement over a significant period.

11:20 a.m.

Panel — Meniere's Disease, Facial Palsy, and Their Treatment

BERNARD J. RONIS, M.D., Philodelphio, Po.

DAVID AUSTIN, M.D., Chicago, Ill.

ARIS M. SOPHOCLES, M.D., Attending in Otoloryngology, The Mercer Hospitol, Trenton

WALTER A. PETRYSHYN, M.D., Upper Montcloir; Clinicol Professor ond Director of Otoloryngology, New Jersey College of Medicine, Jersey City; Associote Attending in Otoloryngology, The Mountoinside Hospitol, Montcloir

MYRON J. SHAPIRO, M.D., Irvington; Attending in Otoloryngology, Nework Beth Isroel Hospitol

Discussion of speakers' papers, together with answers to questions from the audience.

11:45 a.m.

Visit to Exhibits

Sections on

Anesthesiology
Cardiovascular Diseases

Joint Session

Monday Afternoon, May 17, 1965

2:00 p.m.

Election of Officers

2:10 p.m.

Symposium — Cardiac Arrhythmias and Resuscitation

Diagnosis and Management of Common Cardiac Arrhythmias and Cardiac Arrest

MORTIMER L. SCHWARTZ, M.D., Associote Professor of Medicine, New Jersey College of Medicine, Jersey City

Discussor: John A. Kinczel, M.D., Trenton

Most common cardiac arrhythmias can be diagnosed at the bedside by assembling the pertinent historical facts, observing the jugular venous pulse, palpating an arterial pulse, and auscultating the heart. The effect of carotid sinus pressure on the ventricular response is often diagnostic in questionable cases. Vagal pressure, drug therapy, and/or electrical cardioversion can abolish most arrhythmias.

Cardiac arrest must be diagnosed within seconds of onsets. Within three to five minutes, the doctor must start assisted ventilation and external cardiac compression. Electrical means are necessary to stop ventricular fibrillation if present. Appropriate drug therapy must be used and the factors responsible for the arrest eliminated. Substantially, more lives will be saved if not only medical and paramedical personnel are instructed in the first-aid technics of cardiopulmonary resuscitation but if all lay persons are made capable of comprehending and responding to the emergency of cardiac arrest.

Cardiopulmonary Resuscitation Outside the Operating Room

PETER SAFAR, M.D., Professar and Chairman, Department af Anesthesiology, University af Pittsburgh Schaal af Medicine, Pittsburgh, Pa.

Discussor: Joseph Woolwich, M.D., Lang Branch

A public health approach to cardiopulmonary resuscitation requires improved comprehensive community-wide emergency care organization. This should include all three aspects of emergency care, namely: (A) First aid training of the public at large; (B) Ambulance organization; and (C) Hospital emergency room coverage around the clock by a resuscitation team consisting of a physician experienced in resuscitation and technicians. This team should also be available for hospital-wide resuscitation attempts outside the operating rooms. A committee of the American Heart Association developed recommendations concerning what, who and how should be taught. Details of these technics are discussed.

Statewide Resuscitation Program

ALVIN A. FLORIN, M.D., Directar, Heart Disease Pragram, Divisian af Chranic Illness Contral, New Jersey State Department of Health, Trentan

The author describes the organization of a series of one-day courses for physicians in cardiopulmonary resuscitation at the New Jersey College of Medicine and Dentistry. The number trained will be reported with an evaluation of the results achieved. The effects of a completed pilot program for the training of rescue squad workers are presented. Problems relating to the training of nurses, dentists, and other groups are briefly discussed. Future plans for the expansion of these training programs are outlined.

4:15 p.m.

Visit to Exhibits

Section on

Medicine

Monday Afternoon, May 17, 1965

2:00 p.m.

Election of Officers

2:10 p.m.

Symposium — Rehabilitation of the Cardiac and Cerebral Vascular Accident

The Cardiac

WILLIAM A. SODEMAN, M.D., Dean and Vice President far Medical Affairs, The Jeffersan Medical Callege and Medical Center, Philadelphia, Pa.

In heart disease as in no other disease is individual analysis more important. Patients with congestive heart failure or with frequently recurring angina pectoris, and those recovering from coronary occlusion may require adjustments in their total living pattern based upon a number of variables. These include:

(1) The emotional reaction patterns of the individual
(2) Estimates of longevity and invalidism
(3) Estimates of cardiac reserve and evaluation of origin of symptoms (inactivity, cardiac insufficiency, reactive depression, and the like)
(4) Economic considerations

The integration of data in these variables into programs devised for the specific person is discussed, and the principles involved are brought out.

Rehabilitation of the Cardiac

HENRY H. KESSLER, M.D., Newark; Directar, The Kessler Institute far Rehabilitatian, West Orange

The working capacity of individuals who have had coronary attacks has been largely underestimated. Those who have recovered can generally return to their former tasks provided they remain under medical control and supervision. The physical adjustment of these individuals has been hampered by psychologic prejudices of the past and by the medico-legal barriers of the present. A realistic appraisal would give greater encouragement to this type of impairment.

The Cerebral Vascular Accident

JEROME G. KAUFMAN, M.D., Maplewaad; Seniar Attending, Newark Beth Israel Haspital

The subject matter to be discussed will include and stress the importance of differential diagnosis. Many of these are amenable to surgical therapy and some are curable. Laboratory tests and other modern methods for establishing the correct diagnosis are reviewed. The role of *immediate* treatment in preventing permanent disability is considered. Finally, recent advances in the study of this entire problem are presented.

Rehabilitation of the Cerebral Vascular Accident

ALBERT A. MARTUCCI, M.D., Assaciate Prafessar af Physical Medicine, The University af Pennsylvania Graduate Schaal af Medicine; Directar of Physical Medicine and Rehabilitation, Philadelphia General Haspital, Pa.

The author offers a practical approach to the care of the patient who has sustained a stroke. Emphasis is placed on the *immediate* physical medicine rehabilitation procedures necessary to prevent prolonged disability and deformities together with the importance of proper motivation of the professional staff, the family, and the patient. Also presented will be the possibilities of using transcerebral diathermy for its beneficial effects in stimulating brain circulation and helping to remove some of the shocking effects to the brain following a stroke.

4:15 p.m.

Visit to Exhibits

Section on

Rheumatism

Monday Afternoon, May 17, 1965

12:00 noon

Luncheon — Section on Rheumatism

Reservations: Georgia E. Allen, M.D., 436 Second Avenue, Haddon Heights

2:00 p.m.

Election of Officers

2:10 p.m.

Symposium — Rheumatic Fever

Experimental Rheumatic Fever With Comments on the State of Vaccine Prophylaxis

PETER W. VANACE, M.D., Haddanfield; Program and Medical Director, Children's Seashare House, Atlantic City; Director, Juvenile Rheumatoid Arthritis Speciol Treatment Center, Children's Hospitol of Philadelphia, Pa.

Differential Diagnosis of Rheumatic Fever

JOHN H. DONNELLY, M.D., Chief of Cardiac Catheterization Loboratory, Presbyterion Hospital, Nework

The differential diagnosis of rheumatic fever is discussed and illustrated with slides. This includes consideration of lupus erythematous, of other collagen diseases, and of the viral diseases which produce myocarditis, Coxsaxie, infectious mononucleosis, subacute bacterial endocarditis, fetal myocarditis and myocardosis. Also considered are rheumatic fever, rheumatoid arthritis, and familial cardiomegaly.

Since there is a changing character to rheumatic fever, the recognition of atypical aspect of this disease is also illustrated.

Current Methods of Prophylaxis and Treatment of Acute Rheumatic Fever

THOMAS M. GOCKE, M.D., South Orange; Associate Professor of Preventive Medicine, New Jersey College af Medicine, Jersey City

The prevention of rheumatic fever is based upon the control of Group A streptococcal infections. Streptococcal disease, the most frequent bacterial disease of the upper respiratory tract, can be diagnosed accurately by a combined clinical and bacteriologic evaluation and adequately treated by the proper use of antibiotics; and serious non-suppurative complications such as rheumatic fever can and should be prevented. The antibiotic of choice for the treatment of streptococcal disease and the carrier state is penicillin, or in instances of drug sensitivity erythromycin, given for at least 10 days. A single injection of benzathine penicillin (600,000 to 1,200,000 U.) is probably the method of choice. Tonsillectomy is not recommended as a routine measure either to prevent streptococcal infections or rheumatic fever recurrences. Sulfonamides do not eliminate streptococci in established infections but are as effective as oral pencillin for continuous prophylactic purposes. Of these latter regimens aimed at preventing recurrent attacks the most effective has been a monthly injection of benzathine penicillin G, 1,200,000 U. It is still recommended that chemoprophylaxis be maintained indefinitely, particularly for the patient who has rheumatic valvular heart disease, however the risk of recurrence may depend on the age and cardiac status of the individual.

In contrast to prevention, there have been relatively few advances in the treatment of the acute attack of rheumatic fever. Group A beta hemolytic streptococci should be eliminated by prompt penicillin therapy, possibly in high doses initially and certainly maintained during convalescence. Salicylates are the basic therapy of choice in acute rheumatic fever in doses of 30 to 60 mgm. per pound daily for children and 5 to 8 grams per day for adults. There is no doubt that aspirin dramatically relieves the symptoms of polyarthritis and fever in rheumatic fever, but its value in the treatment of carditis and the prevention of cardiac damage has been doubted and the effectiveness of corticosteroids in such patients has been suggested. However, the careful clinical trial of 497 children, observed in 12 centers in the United States, England and Canada did not show any superiority of cortisone or ACTH over aspirin either in response of the acute disease or in heart damage after a one year follow-up. Corticosteroids are still being used but the evidence of their value even early in carditis is questionable.

Great advances have been made in the prevention of rheumatic fever but much less progress has been shown in its treatment.

4:15 p.m.

Visit to Exhibits

Section on

Drug Addiction

A special scientific session orronged and presented in caaperatian with the New Jersey Stote Deportment of Heolth and the Divisian of Mental Heolth and Hospitols of the New Jersey State Department of Institutians ond Agencies.

Tuesday Morning, May 18, 1965

9:30 a.m.

Symposium — Programs and Plans for Medical Care and Rehabilitation for Drug Addiction

Moderator

ROSCOE P. KANDLE, M.D., Commissioner, New Jersey State Department of Health, Trenton

The Extent of the Problem of Drug Addiction in New Jersey

Coptain LEONARD IATESTA, Cammunity Narcotics Squad, New Jersey State Police, West Trenton

Drug addiction has been a matter of public safety and police concern, particularly since the passage in 1914 of the Harrison Act for the control of narcotics. This presentation reviews many aspects of the problem of drug addiction in New Jersey from the point of view of police action and public safety.

USPHS Programs of Medical Care for Narcotic Addicts

JAMES F. MADDUX, M.D., Medical Officer in Chorge, United States Public Health Service Hospitol, Fort Warth, Texas

The U.S. Public Health Service has operated residential treatment programs as well as research and investigations into the causes and the methods of treat-

ment of drug addiction since 1928. Here summarized will be the current role of federal facilities in the medical control of drug addiction.

Drug Addiction: Its Place in the Overall Planning for Comprehensive Mental Health Services in New Jersey

V. TERRELL DAVIS, M.D., Director, Division of Mental Health and Hospitals, New Jersey State Department of Institutions and Agencies, Trenton

The New Jersey Legislature in 1964 adopted an act concerning the commitment, confinement, disposition, care, treatment, and rehabilitation of drug addicts and other persons having drugs illegally in their possession. This re-affirmed the public policy of this State to be that the human suffering and social and economic loss caused by drug addiction are matters of grave concern to our people. It is held to be imperative that a comprehensive program be established and implemented through the facilities of the State, the counties, the federal government, and local and private agencies to prevent drug addiction, and to provide diagnosis, treatment, care, and rehabilitation for drug addicts to the end that these unfortunate individuals may be restored to good health and again become useful citizens in the community.

In accordance with this act the Commissioner has designated Dr. Granville Jones to coordinate and conduct the programs and procedures to be established and to have supervision of the care, treatment, and rehabilitation programs.

This presentation will show how the Division of Mental Health and Hospitals within the Department of Institutions and Agencies is proceeding with the implementation of this legislation within the framework of planning for comprehensive mental health services in New Jersey.

11:45 a.m.

Visit to Exhibits

Session on

Perinatal Mortality

A special scientific session arranged and presented in cooperation with The Academy of Medicine of New Jersey and the New Jersey State Department of Health.

Tuesday Morning, May 18, 1965

9:30 a.m.

Symposium — Perinatal Mortality

Moderator

PHILIP S. BARBA, M.D., Associate Dean and Associate Professor of Pediatrics, The University of Pennsylvania School of Medicine, Philadelphia, Pa.

Methodology of Perinatal Mortality Surveys in the Hospital

SYDNEY H. KANE, M.D., Executive Director, Foundation for Medical Research; Chief of Pediatrics, Frankford Hospital, Philadelphia, Pa.
Discussor: Arthur Heyman, M.D., Rahway

Electronic computers provide an easy and relatively economical technic for the investigation of perinatal problems. A detailed analysis of each individual hospital's work can be provided with comparable tabulations for the entire nation. These data are distributed on a current monthly basis plus annual detailed analyses, providing the hospital "Perinatal Review Group" with useful data at the local level. If real and significant gains in perinatal mortality are to be achieved, they must be accomplished at the individual hospital by means of intelligent review and constructive self-criticism.

The North Carolina Survey on Perinatal Mortality

JAMES F. DONNELLY, M.D., Consultant, North Carolina State Board of Health, Raleigh; Associate Professor of Obstetrics and Gynecology, The University of North Carolina School of Medicine, Chapel Hill, N. C.

Discussor: John D. Preece, M.D., Trenton

The current study includes 2,355 perinatal deaths occuring among 61,140 deliveries in 6 hospitals in North Carolina over the past ten years. Data for all fetal and neonatal deaths as well as for pre-selected controls were collected on a 6-page protocol plus an autopsy supplement. These data indicate an increase in the perinatal mortality rate from the best to the worst economic and social groups. Mothers under age 15 have very high perinatal mortality rates. These descend, reaching the lowest point in the age group 20 to 24. The rates then begin to rise rather rapidly. So far as parity is concerned, the lowest mortality experience was exhibited by the birth order 1 and 2. No remarkable increase in perinatal mortality was noted until birth order 4 but then continued to rise gradually thereafter.

Almost all complications of pregnancy led to an increase in perinatal mortality, some to a greater degree than others. Placental complications, as well as specific pregnancy complications, are accompanied by marked increase in perinatal mortality. The history of previous pregnancy complications as well as intercurrent illness during the current complication are associated with a perinatal mortality which is significantly elevated. The implications of these findings for the practicing clinician are discussed.

A Pathologist Looks at Perinatal Mortality

JAMES B. AREY, M.D., Professor of Pathology, Temple University School of Medicine; Pathologist, St. Christopher's Hospital for Children, Philadelphia, Pa.

Discussor: Irving Weiss, M.D., Morristown

Approximately five percent of all deaths occur during the first twenty-eight days of extrauterine life, and probably at least as many take place during the intrauterine period. Many of the lesions encountered at postmortem are ones which are largely peculiar to this early period of life; e.g., subependymal-intraventricular hemorrhage and pulmonary hyaline membranes. Others (such as broncho-pneumonia) are common to all periods of life. Only through the co-operative efforts of the clinician and the pathologist can a better understanding of the causes of these deaths be forthcoming and can appreciable reductions be effected in the existing mortality rates.

11:45 a.m.

Visit to Exhibits

Session on

Community Mental Health Centers

A special scientific sessian arranged and presented in coaperatian with the Divisian af Mental Health and Haspitals af the New Jersey State Department af Institutians and Agencies.

Tuesday Afternoon, May 18, 1965

2:00 p.m.

Panel — Psychiatric Treatment in the Mainstream of Medicine

Moderator

EVELYN P. IVEY, M.D., Directar, Office af Planning, Divisian af Mental Health and Haspitals, New Jersey State Department af Institutians and Agencies, Trenton

A Resource for the Family Physician

NORMAN L. LOUX, M.D., Medical Directar, Penn Faundatian far Mental Health, Inc., Sellersville, Pa.

This paper describes the development of a comprehensive community psychiatric service. It reviews the philosophy of service with special emphasis to the role that the family physician can play in the development and application of the service. Specific examples are offered to illustrate the manner in which the family physician uses the Community Mental Health Center as a resource and participates in the program. Also discussed will be ways in which the family physician can participate in specific programs which have not yet been realized. The paper will summarize general principles which, hopefully, may be applicable to other communities.

A Resource for the Psychiatrist

WILLIAM FURST, M.D., Attending in Neurapsychiatry, East Orange General Haspital

The Council on Mental Health of the American Medical Association has declared that mental illness is public health problem number one. Dramatic developments during the past decade in psychopharmacology, electro-diagnosis, electrotherapy, individual and group psychotherapy, psychoanalysis, and psychosomatic medicine require prompt psychiatric care in a community medical facility.

The problem of mental illness is so vast that methods must be developed to treat more patients as early as possible, close to their homes, to prevent long term disability and expensive custodial care. The general hospital is the logical center for the provision of necessary multiple services within the frame of reference of Community Mental Health Centers to be established under recent federal legislation.

Tax Support Versus Fee for Services From Individuals, Pre-Payment Plans and other Sources

EDWARD A. MOONEY, Executive Directar, Health Facilities Planning Cauncil for New Jersey, Princetan

There is an increasing demand for inpatient and outpatient psychiatric services. However, the demand must be supported by adequate payment either from the government or by third party prepayment programs. Demand for services and ability to pay for them implies the availability of community mental health centers which are accessible to the public. And before any payment determination can be made, it is necessary to obtain estimates of cost based on utilization experience.

National organizations are requesting more psychiatric coverage for their employees, placing increasing responsibilities on the providers of such services. Payment by the government or third parties is related to the adequacy of staff, approved facilities, and reasonable costs.

4:15 p.m.

Visit to Exhibits

Session on

Cancer Chemotherapy

A special scientific sessian arranged and presented in coaperatian with The Academy af Medicine af New Jersey and the New Jersey State Department af Health.

Tuesday Afternoon, May 18, 1965

2:00 p.m.

Symposium — Cancer Chemotherapy

Moderator

BERNARD J. KOVEN, M.D., Englewaad; Assistant Prafessar af Medicine and Director, Oncalagy Divisian, New Jersey Callege af Medicine, Jersey City.

Cancer Chemotherapy Agents

ROBERT GOLBEY, M.D., Assaciate Attending Physician, Memarial Slaan-Kettering Cancer Center, New Yark, N. Y.

Chemotherapy of Lymphoma and Leukemia

HARVEY D. ROTHBERG, M.D., Attending in Medicine, Princetan Haspital

Chemotherapy of Solid Tumors

BURTON J. LEE, M.D., Clinical Assistant Physician, Memarial Haspital; Research Assaciate, Slaan-Kettering Institute, New Yark, N. Y.

The panel members will discuss the current concepts in the development and clinical applications of cancer chemotherapy agents. The categories of agents and the merits and disadvantages of individual and new drugs will be considered. In addition, specific clinical settings in which the drugs have special value (or may be actually contra-indicated) will be mentioned. Time will be allowed for a question and answer period.

4:15 p.m.

Visit to Exhibits

Section on

Dermatology

Wednesday Morning, May 19, 1965

9:45 a.m.

Election of Officers

10:00 a.m.

Progestin-Estrogen Combinations in Management of Acne

GEORGE H. KOSTANT, M.D., Irvington; Associate Clinical Prafessor of Dermotology and Syphilology, New York University School of Medicine, New York, N. Y.

The paper reviews the history of progestin-estrogen combinations in the treatment of acne vulgaris. The rationale for this approach is discussed. Studies of quantitative sebum analysis of the skin are outlined.

A clinical evaluation is presented of 25 females studied on cyclical therapy with norethindrone and mestranol. Indications for, and side effects resulting from, this type of therapy are emphasized.

10:20 a.m.

The Action and Indications for Solid Carbon Dioxide Therapy in Selected Dermatoses

SAM C. ATKINSON, M.D., Morristown; Assistant Clinical Professor of Dermotology, Cornell University Medical College, New York, N. Y.

Routine indications for solid carbon dioxide (dry ice) therapy include acne, keloids, superficial angiomas, keratoses, verruca, and occasionally discoid lupus erythematosus. Certain granulomas and inflammatory diseases may also be treated successfully with solid CO2. A number of Kodachromes will be shown to explain the gross and microscopic effect of CO2 therapy on a variety of granulomas and selected basal cell carcinomas.

10:40 a.m.

The Dermatologist, the Cosmetic Chemist, and the New Food, Drug, and Cosmetic Act

EARLE W. BRAUER, M.D., Jersey City; Associate Professor of Clinical Dermotology, New York University School of Medicine, New York, N. Y.; Medical Director, Revlon Research Center, Inc., Bronx, N. Y.

In a review of the new Food, Drug, and Cosmetic Act through the eyes of a dermatologist, the significant benefits derived by patient and consumer are discussed and the extent of responsibility of the manufacturer, pharmaceutical, and cosmetic is identified. Interpretations of the new regulations also directly effect the physician in his role as practitioner, clinical investigator, consultant to industry or research coordinator.

11:00 a.m.

Clinical and Laboratory Diagnostic Procedures in Photosensitivity Diseases

LEONARD C. HARBER, M.D., Associate Professor of Dermatology, New York University School of Medicine, New York, N. Y.

Differential diagnosis of light eruptions based on the demonstration of biochemical and serologic factors will be stressed. Specific diseases to be mentioned include porphyria cutanea tarda, erythropoietic protoporphyria, solar urticaria, drug eruptions, and polymorphous light eruptions. Discussion and illustrations and positive photographic testimony in these diseases will also be included.

11:45 a.m.

Visit to Exhibits

Sections on

Gastroenterology and Proctology
General Practice
Radiology
Surgery

Joint Session

Wednesday, May 19, 1965

9:30 a.m.

Election of Officers

9:45 a.m.

Symposium — Colonic Bleeding

Diagnosis

Etiology of Colonic Bleeding

LAWRENCE H. WARBASSE, JR., M.D., Director of Medicine, Nework City Hospitol

Sigmoidoscopic Differentiation of Colonic Bleeding

JAMES EDSON, M.D., Attending in Proctology, Paterson Generol Hospitol

This paper briefly describes the diagnostic features of the ulcerative diseases of the large bowel that are

visualized through the sigmoidoscope. Also presented will be a review of the growths that commonly bleed into the large bowel. The author plans to project on to the screen some colored transparencies taken through the sigmoidoscope.

Roentgen Diagnosis of Colonic Bleeding

GERALD D. DODD, M.D., Clinicol Professor of Radiology, The Jefferson Medicol College, Philadelphia, Po.

The causes of colonic bleeding (amenable to radiologic diagnosis) are discussed and illustrated. Emphasis is placed on differential diagnosis and various modifications of technics which have proved useful for differential diagnosis.

Panel Discussion

Moderator

PHILIP D. GILBERT, M.D., Chief, Department of Rodiology, Cooper Hospital, Camden

Panelists

LAWRENCE H. WARBASSE, JR., M.D., Newark

JAMES EDSON, M.D., Patersan

GERALD D. DODD, M.D., Philadelphio, Po.

ANTHONY L. RIFICI, M.D., Asbury Pork; Attending in Medicine, Fitkin Memorial Hospital, Neptune

C. RICHARD WEINBERG, M.D., Director of Radiology, Newark City Hospital

Discussion of speakers' papers, together with answers to questions from the audience.

11:45 a.m.

Visit to Exhibits

2:00 p.m.

Treatment

Hematologic Aspects of Treatment of Colonic Bleeding

PETER A. MIESCHER, M.D., Professor af Medicine, New York University School of Medicine, New York, N. Y.

Hematologic causes of colonic bleeding may be divided into two main groups:

In Group I, colonic hemorrhage occurs in association with purpura (which may be thrombocytopenic or non-thrombocytopenic), the colonic lesion being only one manifestation of generalized bleeding.

Conversely, in Group 11, bleeding from the colon only, is associated with a coagulation defect (congenital or acquired), which may have been asymptomatic. Minor trauma may thus cause massive hemorrhage. Once diagnosed by laboratory tests, such defects are often amenable to specific therapy.

Medical Treatment of Bleeding in Ulcerative Disease of the Colon

ABRAHAM I. FRIEDMAN, M.D., Hackensack; Chief, Department af Gastroenterology, Bergen Pines County Hospital, Paramus

Significant bleeding from ulcerative disease of the colon includes (in the order of frequency) generalized nonspecific ulcerative colitis, ulceration of an adenoma, diverticulitis, granulomatous colitis, primary nonspecific ulcer of the colon, amebic dysentery, bacillary dysentery, lymphogranuloma venereum, and anal ulcer.

The most serious type of bleeding occurs in association with chronic ulcerative colitis, diverticulitis, and granulomatous colitis. Bleeding in diverticulitis is occasionally massive and may require emergency surgery. Expectant, conservative, medical therapy is the treatment of choice in ulcerative colitis and granulomatous colitis. The use of steroids is encouraged despite bleeding. Occasionally surgical intervention is necessary to control bleeding.

Surgical Treatment of Colonic Bleeding

HARRY E. BACON, M.D., Professor ond Chairman, Deportment of Rectal Surgery, Temple University School af Medicine, Philadelphio, Po.

The surgical management of bleeding from the colon is contingent upon many factors, it being assumed that the colon alone is the offending organ under consideration; and that the esophagus, stomach, small intestine, and rectum are to be deleted from the discussion. It is important to ascertain the *character* of the bleeding, the amount, and whether it is a single acute episode or whether it occurs periodically over a period of time. A careful and detailed history is an invaluable aid in establishing a diagnosis. While preparation for infusion of blood is being made, if indicated, at least a hematocrit, hemoglobin, and red cell count determination should be instituted—and where possible, a complete survey and blood volume. Modern hematologic technics offer rapid qualitative and quantitative analyses and provide dependable guides for adequate replacement of blood, which is the most essential supportive measure.

Every effort should be made to determine the cause of the bleeding. Nasogastric intubation, a flat plate of the abdomen, roentgenographic studies (using a thin suspension of barium without preliminary preparation), and contrast air studies may prove invaluable.

We have on occasion explored the abdomen and visualized the bowel lumen endoscopically through a slit in the mid sigmoid and another in the proximal transverse colon under aseptic precautions, but this should not be done unless repeated studies have been uninformative. In the presence of massive colonic hemorrhage, laparotomy reveals the source in only 30 per cent of the cases.

In the young, intussusception and Meckels diverticulum are the most common cause of colonic bleeding; in the adult, cancer, adenomatous polyps, diverticular disease, and ileocolitis and ulcerative colitis are the common offenders.

Panel Discussion

Moderator

C. BUCKMAN KATZENBACH, M.D., Clinical Instructor in Surgery, New York University School of Medicine, New York, N. Y.; Assistant Director of Surgery, Hunterdon Medical Center, Flemington

Panelists

PETER A. MIESCHER, M.D., New York, N. Y.

ABRAHAM I. FRIEDMAN, M.D., Hockensack

HARRY E. BACON, M.D., Philadelphia, Pa.

GEORGE C. PARELL, M.D., Post-President, New Jersey Acodemy of General Practice; Chief of Rectal Clinic, St. Michael Hospitol, Newark

KENNETH H. JUDY, M.D., Professor ond Choirman, Deportment of Surgery, New Jersey College of Medicine, Jersey City

Discussion of speakers' papers, together with answers to questions from the audience.

Section on

Metabolism

Wednesday Morning, May 19, 1965

9:45 a.m.

Election of Officers

9:55 a.m.

The Kidney in Diabetes Mellitus

NORMAN LASKER, M.D., Associate Professor of Medicine, New Jersey College of Medicine, Jersey City; Consultant in Renol Diseoses, United States Public Heolth Service Hospital, Staten Islond, N. Y.

Diabetic nephropathy is now the leading cause of death in juvenile diabetes mellitus. It is also an increasing cause of death in adult onset diabetes mellitus. Diabetic nephropathy includes arterio- and arteriolosclerosis, pyelonephritis, and glomerulosclerosis. Current concepts as to the nature, etiology, diagnosis, prevention, and treatment of diabetic nephropathy are presented.

10:15 a.m.

Diseases of Mitochondria

LeROY A. PESCH, M.D., Professor and Chairmon, Deportment of Medicine, Rutgers University Medicol School, New Brunswick

As our understanding of diseases of metabolism grows, the pathologic physiology underlying some of these disorders can be localized to changes occurring in various cellular components. Based on these correlations between alterations in cellular structure and function in a variety of human diseases, an attempt will be made to show how cellular pathologic physiology can lead to new possibilities for the classification of these diseases. Special emphasis is directed to disease states due in part at least to change in the function of mitochondria.

10:35 a.m.

Pre-Diabetes

LESTER HENRY, M.D., Professor of Medicine, Howord University Collage af Medicine, Woshington, D. C.

This presentation reviews the development of our concepts of diabetes mellitus. Retrospective studies of diabetics indicate the presence of an abnormality long before the diagnosis of diabetes mellitus is made or before an abnormality in the blood sugar can be detected. At this point, some emphasis will be placed on the obstetrical history of such patients with stress on an earlier appreciation of the disease and reduction of fetal mortality. The author reviews the findings of insulin assay in the early diabetic, the presumed pre-diabetic, and normal persons as it relates to the true defect in diabetes. The paper concludes with comment on the possibility of using a simple sugar, such as fructose, in the early diagnosis of the diabetic state.

11:00 a.m.

Differential Diagnosis of Masculinizing Syndrome in the Female

ABRAHAM RAKOFF, M.D., Professor of Obstetrics ond Gynecology (Endocrinology), Jefferson Medical College, Philodelphio, Po.

Increased secretion of androgen in the female results in hirsutism and may progress to frank virilization with deepening of the voice and enlargement of the clitoris. In addition, there is some inhibition of ovarian function resulting in anovulation and amenorrhea. The possible etiologic factors include (1) The adrenogenital syndrome, due to adrenal cortical hyperplasia or to adrenal cortical tumors; (2) Cushing's syndrome; (3) masculinizing tumors of the ovary; (4) Stein-Leventhal syndrome; and (5) genetic hirsutism with associated ovarian dysfunction.

Laboratory studies helpful in the differential diagnosis are: (a) 17-ketosteroid determination; (b) fractionation of 17-ketosteroids; (c) pregnantriol determination; (d) ACTH stimulation test; (e) dexamethasone suppression test; (f) culdoscopy; and (g) x-ray visualization of pituitary, adrenals, and ovaries.

11:25 a.m.

General Discussion

11:45 a.m.

Visit to Exhibits

12:00 noon

Luncheon — Section on Metabolism

Reservations: John F. Marshall, M.D., 131 Perry Street, Trenton

Section on

Ophthalmology

Wednesday Morning, May 19, 1965

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium — Corneal Infections

FRANCIS P. FURGIUELE, M.D., Assistont Professor of Ophtholmology, Temple University School of Medicine; Attending Surgeon, Chestnut Hill Hospital, Philadelphia, Po.

Corneal ulceration may result from many causes ranging from simple trauma due to scratches to central ulcers caused by virulent bacteria. Prompt recognition of the etiology is of paramount importance for proper management. Failure to institute appropriate studies and treatment is often responsible for prolongation of the disease, which ends in extensive scarring and, at times, endophthalmitis.

A clinical classification based on etiology and geographic location is a helpful first step in proper medical management. Selection of the appropriate antibiotic or chemotherapeutic agent after obtaining laboratory tests is next. Knowledge of the necessary dose and route of administration of the medications to be used offers the best chance for rapid cure. In spite of the best medical management, surgical intervention (lamellar keratoplasty) is sometimes required to achieve a favorable outcome.

ROBERT A. D'AMICO, M.D., Attending Surgeon and Director, Corneol Diseoses, Horlem Eye ond Ear Hospitol, New York, N. Y.

The relationship of keratoplasty to corneal infections is the topic of this discussion.

The presence of active corneal infection is ordinarily a contra-indication to corneal transplantation for visual rehabilitative purposes. On the other hand, chronic or rapidly progressive corneal infections may be so destructive to corneal substance that keratoplasty may be advisable as a therapeutic measure.

Procedures concerned with functional goals must be postponed to a more favorable time. Varying technical approaches in the surgical procedures are described.

The handling of infection complicating the immediate post-operative period in keratoplasty is discussed.

ROBISON D. HARLEY, M.D., Associate Professor of Ophthalmology, Temple University School of Medicine, Philadelphia, Po.; Chief Attending in Ophtholmology, Atlantic City Hospitol

Non-perforating and perforating wounds of the cornea are among the most common injuries seen by the ophthalmologist today. The author will project a series of color slides depicting characteristic lesions, accompanied by a brief discussion of their management.

ALFONSE A. CINOTTI, M.D., Assaciate Professor of Surgery, New Jersey College of Medicine; Director of Ophtholmology, Jersey City Medical Center

The extent to which systemic diseases contribute to opacification of the cornea is not known. Conditions such as syphilitic interstitial keratitis, keratomalacia, ulceration from viral diseases and acne rosacea keratitis are well known. Many obscure conditions are related to fat and protein metabolism which may be responsible for corneal changes. The study of these metabolic disorders by slit lamp biomicroscopy can be helpful in diagnosis.

11:45 a.m.

Visit to Exhibits

Section on

Orthopedic Surgery

Wednesday Afternoon, May 19, 1965

2:00 p.m.

Election of Officers

2:10 p.m.

Symposium on Fractures

Fractures of the Humerus and Shoulder

CHARLES S. NEER, II, M.D., Associate Professar af Clinical Orthopedic Surgery, Columbio University College of Physicians ond Surgeons; Attending in Orthapedic Surgery, New York Orthopaedic Hospital, N. Y.

This is a discussion of the acute fractures and fracture-dislocations of the proximal humerus with a consideration of treatment in the light of the pathologic anatomy.

Displaced Bimolleolar Fractures of the Ankle

L. ARNE SKILBRED, M.D., Attending in Orthopedic Surgery, The Mountainside Hospital, Montclair

Forty-six displaced bimalleolar fractures of the ankle were evaluated by the authors as to subjective, objective, and radiologic findings, at an average follow-up time of eight years. Fractures treated openly were compared with the ones treated by closed technics. These fractures were all treated at the Fracture Service of the Presbyterian Hospital, Columbia-Presbyterian Medical Center, between 1929 and 1961.

General Discussion

Scientific Exhibits

Exhibit Hours
9:00 a.m.—5:00 p.m., Monday and Tuesday
9:00 a.m.—3:00 p.m., Wednesday
May 17, 18, and 19, 1965

Total Management of Parkinson's Disease: Neurosurgical Thalamotomy, Drug Therapy, and Rehabilitation

DAVID J. LaFIA, M.D., WILLIS E. MANGES, M.D., JAY A. WENGER, M.D., H. FRAZER PARRY, M.D., Methadist and Magee Memarial Haspitals, Philadelphia, Pa.

This exhibit describes various aspects of a multi-discipline approach to the management of Parkinson's disease. The authors point out that by combining drug treatment and rehabilitation with thalamotomy, significant symptomatic relief has been offered to about 90% of the patients in their series.

Laboratory and Clinical Studies With Diphenidol, A New Antiemetic Agent

ARTHUR LIPSCHUTZ, M.D., CARL C. FISCHER, M.D., Hahnemann Medical College and Haspital, Philadelphia, Pa.

An antiemetic related to, but not, phenothiazine has been shown to be non-toxic in animal studies, and has shown 80% effectiveness in all types of non-surgical nausea and vomiting in children. Mechanisms of vomiting are discussed in children.

A Ten-Second Colorimetric Test for Asymptomatic Bacteriuria in Pregnancy

EUGENE J. SLOWINSKI, M.D., LEON G. SMITH, M.D., St. Michael Haspital, Newark

Asymptomatic bacteriuria has been shown to lead to acute pyelonephritis, abortion, prematurity, and toxemia of pregnancy. The usual tests for this condition are expensive and time consuming. Our study as shown in the exhibit demonstrates a very inexpensive, simple, rapid, and reliable colorimetric urine test to detect asymptomatic bacteriuria in pregnant patients. The exhibit describes and correlates the Griess test with the usual urine culture and colony count on "clean catch" morning specimens in 500 pregnant clinic and private patients. The number of patients detected with asymptomatic bacteriuria by this unsupervised collection technic was 38 (8%) and, of these, 26 (or over two-thirds) were also detected by the Griess Test. Griess testing costs less than one cent and, when repeated three times on each patient, should be able to detect 95% of all cases of asymptomatic bacteriuria in pregnancy. These should then be tested for predominant organism and sensitivity studies to prepare for appropriate therapy.

The Value of an Inhalation Therapy Department

GENE L. D'ALESSANDRO, M.D., DANIEL HOPLER, STEPHEN MATALAGA, Presbyterian Unit, United Haspitals af Newark

An Inhalation Therapy Department can be of great value in every modern general hospital. The different technics available are described. The value of Intermittent Positive Pressure Breathing in the pre and postoperative patient is discussed with special reference to patients undergoing heart and lung surgery. The education and rehabilitation of the emphysema patient is illustrated. Inhalation Therapy is a valuable aid in the care of both medical and surgical patients.

The Growth of the Fibula in Premature Infants

ELSIE H. CHU, M.D., HANS G. KEITEL, M.D., INEZ SMITH, M.D., The Jeffersan Medical College, Philadelphia, Pa.

The safety for neonatal use of all antimicrobial agents is being re-evaluated. In the case of oxytetracycline there is no evidence suggesting: a toxic accumulation of the drug in the blood, or a disturbance in bilirubin metabolism, or an untoward effect on weight gain. However, recently published data suggest that tetracycline inhibits linear growth of the fibula in the neonatal period while weight gain remains normal. Every third premature (birth weight less than 2500 grams on admission) was assigned to receive oxytetracycline—7.5 mg. IM every 12 hours for 10 days. Other admissions served as controls. An equal number of infants in both groups received regular and concentrated formulas—given *ad libitum*. Only those infants remaining clinically normal are included in our results.

Chronological Development of Hypothermia

LESTER BARNETT, M.D., CHARLES ZUKAUKAS, M.D., THEODORE PETRUCH, M.D., MAXIM ASA, PH.D., LESTER CHAPMAN, Manmauth Medical Center, Lang Branch

This exhibit has a double purpose: educational and practical which offers the physician another mode of therapy in the control of G.I. hemorrhage through an illustration of chronological development of hypothermia which includes: (a) an internal cooling apparatus; (b) an external cooling unit for general body hypothermia and lymph freezing.

Special features to be shown are our laboratory developments of objective criteria and apparatus which determines the optimal amount of coolant to be introduced instead of present practice of academic guess.

Anxiety or Depression

SEYMOUR DIAMOND, M.D., EDWIN FELDMAN, M.D., Samuel H. Flamm Faundatian, Chicaga, Ill.

In this exhibit, groupings are shown that will differentiate endogenous depression from anxiety neurosis complicated by secondary depressive symptoms. The elucidation of these symptoms is the result of accurate global observation of the patient by the physician, medical examination to rule out physical disease and careful critical history taken. In most instances, the generalist or internist can most adequately diagnose and treat these types of cases.

Photography as an Ophthalmic Investigation Tool

THOMAS BEHRENDT, M.D., The Jeffersan Medical College Department af Ophthalmalagy, Philadelphia, Pa.

Demonstrate capabilities of photography in research and clinical ophthalmology.

The Diagnosis, Medical, Surgical, and Rehabilitative Treatment of the Stroke Patient in the Acute General Hospital

ALVIN A. FLORIN, M.D., M.P.H., New Jersey State Department of Health, Trentan; ARTHUR WINTER, M.D., Stroke Project, East Orange General Haspital; I. RAY HOWARD, M.D., Caldwell

Consultation provided by Arthur Winter, M.D., East Orange Stroke Project, presents the medical history including onset symptomology, previous pathology, and diagnostic studies with angiographies of selected cases at the East Orange General Hospital. Also included in the exhibit is the medical summary of the surgical treatment of the selected patients, together with data on mortality. A film on endarterectomy made by Neurosurgeon, Dr. Arthur Winter, is also to be presented. Dr. Winter comments on his procedure in the film.

Use of a Coronary Vasodilator Following Myocardial Infarction

PHILIP LISAN, M.D., Hahnemann Medical College and Haspital, Philadelphia, Pa.

The classical avoidance of the use of vasodilator substances immediately following acute myocardial infarction is based upon the possible aggravation of hypotension and/or tachycardia, thereby increasing the work load of a damaged heart. This concept persists despite the currently acknowledged benefits of improved myocardial blood flow and myocardial oxygenation provided by such an agent.

An axillary benefit to the damaged myocardium would be the establishment of functional collateral circulation, apparently promoted by pre-treatment of subjects with long-acting coronary vasodilator, Pentaerythritol Tetranitrate. Such aid in the development of collateral flow is postulated to be critical factor in survival following acute myocardial insults.

The availability of a vasodilator having a prolonged and predictable safe effect permits the controlled clinical evaluation of such agent in the immediate post-myocardial-infarction patient. The first aim of such an evaluation would be to determine the safety of such usage; therefore the study would be expanded to allow a statistically valid comparison of the drug's effect upon morbidity and mortality.

An initial controlled pilot study in 34 patients confirms the safety of such an approach.

As a part of a large multi-institutional evaluation of Pentaerythritol Tetranitrate in the acute phase of myocardial infarction, this department has expanded its series in order to do statistical comparisons of both safety and mortality data.

A Simple Bedside Ventilatory Test for Bronchial Asthma

LEONARD S. GIRSH, M.D., LOUIS TUFT, M.D., Temple University Medical Center, Philadelphia, Pa.

Pulmonary function studies were performed simultaneously with sound recordings of the chest of asthmatic patients. The correlation of these studies has shown that airway obstruction as measured by abnormalities in Timed Vital Capacity and Maximal Expiratory Flow Rate corresponds with airway obstruction as observed by the physical findings of an asthmatic wheeze with forced expiration.

A simple useful office ventilatory test, consisting in the elicitation of a wheez upon auscultation of the chest after forced expiratory effort with the patient both in the erect and in the recumbent postures, has been utilized in comparative studies performed in 72 asthmatic patients and in 100 normal controls. These graded auscultatory findings correlate well with the results of pulmonary function studies. This was true both after change in the position and after bronchodilator therapy. The increase in wheezing and decrease in pulmonary function observed, when asthmatic patients changed from the erect or sitting to the recumbent position, offer a possible explanation for the long-recognized aggravation of asthma at night.

Clinical Evaluation of a New Diuretic

ARTHUR BERNSTEIN, M.D., MELVIN ODZE, M.D., ASA H. CREWS, M.D., EDWIN L. ROTHFELD, M.D., FRANKLIN SIMON, M.D., Newark Beth Israel Haspital

Ethacrynic Acid (2,2-dichloro-4(2 methylenebutyryl) phenoxyacetic acid, one of a new group of diuretics, effects a striking increase in sodium and chloride excretion as well as a water diuresis in patients who are refractory to other diuretics. In normal subjects and in patients with congestive heart failure, the pattern responsiveness differs from that of the thiazide or mercurial diuretic response. The agent is rapidly effective with a short total duration of action when given in doses of 50-150 mg. by mouth or intravenously by slow drip. Refractoriness to the drug has not been observed in patients with edema of hepatic, cardiac, and renal origin who have been treated. Side effects observed to date have included elevation of the uric acid, lowering of the postassium, and an alkalosis. These effects are overcome by manipulation of dosage or by supplemental therapy. Use of this drug in a group of 25 patients will be demonstrated to show dose response as well as interaction with the chlorothiazide diuretics and aldactone, thereby adding to the armamentorium of the therapist.

Prehypertension

JAMES C. HUTCHISON, M.D., Abingtan Memarial Haspital, Pa.

Prehypertension is potentially dangerous and may be ultimately fatal because it is the earliest stage of a gradual progressing elevation of the blood pressure leading to sustained hypertension with increased atherosclerotic complications, decrease in life expectancy, and increase in mortality. Therefore, preventive medicine is indicated. The objectives are rest and reorganization of the patient's schedule and attitude, with moderation as the goal. The physician must allow the patient to realize the importance of following his disease at regular intervals, but not in making a hypochondriac of his patient. Finally, the guiding precept of drug therapy should be the careful avoidance of over-treatment.

Interference With the Pathways of Pain

A. LEWIS KOLODNY, M.D. Baltimare, Md.

This exhibit presents graphically the analgetic drugs —their classification and sites and modes of action. It describes particularly a new non-addictive phenothiazine derivative, methotrimeprazine, and compares its clinical effect with that of morphine in a double-blind, crossover study involving 100 patients.

Clinical Applications of Dialysis

CHARLES H. HEIDER, M.D., GADDO ONESTI, M.D., ROBERT H. SELLER, M.D., ALBERT N. BREST, M.D., Hahnemann Medical College and Hospitol, Philadelphio, Pa.

This exhibit describes the use of the artificial kidney and peritoneal dialysis in the management of such conditions as acute and chronic renal failure, drug intoxications, and intractable congestive heart failure. Charts indicating the principles of dialysis and results obtained in typical case histories are presented.

The Inhibition of Fibrinolysis Associated with Certain Hemorrhagic States

WILLIAM M. SWEENEY, M.D., CHARLES J. MASUR, M.D., EDWARD DeRENZO, PH.D., Bergen Pines County Hospital, Paramus

Aminocaproic acid is shown to inhibit fibrinolysis, both *in vitro* and *in vivo*. The mechanism involves inhibition of plasminogen activator substances and, to a lesser degree, inhibition of plasmin activity. Uncontrollable bleeding due to fibrinolysis of clots may occur as a complication of trauma, shock, surgery, cirrhosis of the liver, and in certain obstetrical emergencies. The possible clinical usefulness of aminocaproic acid in the treatment of hemorrhage secondary to fibrinolysis is discussed.

Premedication Without Narcotics: A Statistical Review of 7,500 Case Reports of 15,000 Patients in Study

GEORGE WALLACE, M.D., Methodist Hospital, Brooklyn, N. Y.

The thesis that elective procedures in anesthesiologic practice do not require narcotic premedication is illustrated. A statistical review of 7,500 reports taken at random from a total of 15,000 such cases is presented. The material exhibited emphasizes the value of a tranquilizing type of premedicant drug in an unselected, widely varied group of patients. The generally accepted criteria for adequate premedication are satisfied, and the conclusions drawn are that narcotic drugs, which often produce homeostatic alterations, are not necessary in the premedication regime.

The Primary Prevention of Rheumatic Fever by the Identification of Beta Hemolytic Strep Through Conventional Culturing Methods in the Office or General Hospital

ALVIN A. FLORIN, M.D., M.P.H., New Jersey State Department af Health; HENRY J. DREZNER, M.D., New Jersey Heart Association, Trentan

Will show a method for primary prevention of rheumatic fever by conventional culturing technics. Also shown will be a review of the Modified Jones Criteria used in the diagnosis of acute rheumatic fever. In addition, there will be a resume of the American Heart Association recommendations for the treatment of streptococcal pharyngitis.

Micro-Surgery of the Ear

I. M. SCHNEE, M.D., Barnert Memorial Hospital, Paterson

The purpose of the exhibit is to demonstrate pictorially the procedures performed with the aid of the operating microscope. The exhibit shows the findings and methods of management of common disorders of the ear. The following operations will be shown:

Stapedectomy for otosclerotic deafness

Tympanomastoidectomy for erradication of chronic middle ear and mastoid disease.

Tympanoplasty for restoration of hearing loss caused by disease and injury.

Myringoplasty

Foreign Body Removal

Myringotomy; aspiration of the middle ears and polyethylene intubation for serous otitis media.

All of these will be illustrated with enlarged photographs and transparencies taken at the time of surgery. The method of anesthesia will be demonstrated by the anesthesia department of the hospital.

Surgical Management of Ulcerative Colitis and Diffuse Familial Adenomatosis

HARRY E. BACON, M.D., P. V. MARTIN, M.D., C. M. MAGSANOC, M.D., J. E. PEZZUTTI, M.D., W. D. SMITH, M.D., R. R. GUTIERREZ, M.D., Temple University Medical School and Hospital, Philadelphia, Pa.

A series of color transparencies and two montages showing pathology and steps in surgical management of ulcerative colitis and diffuse familial adenomatosis; statistics covering mortality and morbidity are shown.

Improving the Radical Mastectomy

LESTER A. BARNETT, M.D., Monmouth Medical Center, Long Bronch

The exhibit purports to show various operative and postoperative technics that may improve the results of radical mastectomy for breast cancer. Presented are brief discussions and illustrations of the incision, modifications of skin grafting, ten points to be observed in reducing local recurrences, the use of suction catheters, promotion of good wound healing with complete restoration of function, prevention of lymphedema, and care of the emotional storm. An original three-year study of a continuous operative intravenous drip of triethylenethiophosphoramide, in addition to three-day prophylactic chemotherapy, is part of this presentation. Patient photographs are used to illustrate each point, and results of these technics are statistically summarized.

Biliary—Hepatic Duct—Atresia

JULIAN A. STERLING, M.D., Albert Einstein Medical Center, Philadelphia, Pa.

Transparencies and charts are used to narrate the etiology, pathogenesis, and clinical features of treated and untreated biliary—hepatic duct—atresia as far as is known today. Gaps of knowledge are noted. Use of artificial bile ducts in order to establish an internal hepato-enteric fistula is described. Observations on infants with and without use of artificial bile ducts are recorded.

Progress in Design and Development of Artificial Heart Valves

JULIO C. DAVILA, M.D., ELIZABETH LAUTSCH, M.D., D. A. DeLAURENTIS, M.D., R. S. SETHI, M.D., F. ENRIQUEZ, M.D., O. WILCOX, B.S., T. E. PALMER, Temple University Medical Center, Philadelphia, Pa.

The exhibit illustrates the progress in the development of artificial cardiac valves through over seven years of animal, clinical, and hemodynamic studies. The mechanics and engineering aspects of the prosthetic valves are depicted, including tissue acceptance, fatigue and wear resistance, adaptability of the various designs, and turbulence and flow patterns. The problem of thrombosis is traced with laboratory and clinical studies. Gross and microscopic structural studies of the normal and diseased valves, through special technics, are emphasized.

The Role of Inguinal Hernia in Blunt Abdominal Trauma

BENJAMIN A. PAYSON, M.D., SIGMUND MAGE, M.D., Beekman-Downtown Hospital, New York, N. Y.

It is not generally appreciated that the presence of an inguinal hernia may be a major factor contributing to acute small intestinal perforation secondary to blunt abdominal trauma. Such a happening may occur regardless of whether the force is by direct or indirect muscular contraction, whether it be of trivial magnitude, and whether it be applied to the inguinal area or at a distance from it. By means of diagramatic sketches, operative photographs, and case illustrations, the mechanism of the perforation and the pathology are described. In the management of blunt abdominal trauma it becomes a primary responsibility of the clinician to determine the presence of an inguinal hernia and to inquire of the possibility of trauma as an etiological factor. In any patient revealing peritoneal irritation of undetermined origin with a possible but uncertain history of trauma, the finding of an inguinal hernia establishes a valid indication for surgical exploration.

A Sutureless Prosthesis for Complete Mitral Valve Replacement

ROBERT A. O'CONNOR, M.D., IRVING A. SAROT, M.D., SHELDON O. BURMAN, M.D., CIRO ARMELLINI, M.D., New York Medical College, New York, N. Y.

The purpose of the exhibit is to demonstrate the use of a sutureless prosthesis for complete mitral valve replacement, especially in the poor-risk patient who cannot tolerate a prolonged operation. Cineangiocardiograms will be presented illustrating the hemodynamics of complete mitral insufficiency. A color film will be shown of the actual operative insertion of the prosthesis within a period of 5 minutes. Cinefluorograms will follow showing the radio-opaque valve functioning in vivo and pre- and postoperative pressure studies will document the correction of the defect. An amplified recording made through a stethoscope will be available to illustrate the phonodynamics of the functioning valve.

Lymphography in the Diagnosis and Treatment of the Cancer Patient

JOSEPH R. WILDER, M.D., J. HAROLD BENNETT, M.D., JOSEPH ELFENBEIN, M.D., RICHARD GLATZER, M.D., Hospital for Joint Diseases, New York, N. Y.

The technic and representative findings of over 100 lymphograms are represented, emphasis is placed on the diagnosis of the various types of abdominal cancer, pre- and postoperative lymphography in radical cancer surgery and lymphography in benign diseases of the lymphatics.

Renal Transplantation in Dogs

AARON D. BANNETT, M.D., MAURICE BLACK, M.D., ANTERO COELHO NETO, M.D., MANUEL GALVEZ, M.D., Albert Einstein Medical Center, Philadelphia, Pa.

The technic of renal transplantation in dogs is presented. The physiologic and pathologic changes are then depicted in autografts and unmodified homografts. The clinical, bio-chemical, and pathologic findings are compared.

Cosmetic Plastic Surgery

WALTER M. RYAN, JR., M.D., Monmouth Medical Center, Long Branch; Fitkin Memorial Hospital, Neptune

Recent advancements in cosmetic plastic surgery. Large and medium color photographs of individual problem cases and continuous projection of colored slides of cases requiring cosmetic plastic surgery. Conclusion: cosmetic plastic surgery can assist the physician in the care of his patients.

The Treatment of Scoliosis by Spine Instrumentation and Fusion

CHARLES I. NADEL, M.D., New Jersey Orthopaedic Hospital, Orange

Spine instrumentation in the treatment of Scoliosis as developed by Dr. Paul Garrington has proved to be a useful tool in the treatment of this condition. It provides an excellent means of correcting the curves in that the forces are applied directly to the vertebrae. This, coupled with an adequate fusion, provides one of the best methods of obtaining and maintaining correction. The use of a body cast is necessary to assist in stabilization until the fusion becomes solid. A series of cases is presented demonstrating the use of spine instrumentation and fusion in the treatment of Scoliosis.

New Concepts in Antibiotic Usage: Tissue Levels and Metabolic Pathways of Nafcillin

HOWARD L. NUNES, M.D., New Jersey College of Medicine, Jersey City

This exhibit embodies present and past concepts concerning value of tissue level versus serum levels while demonstrating the pathway of nafcillin metabolism through study of concentration of this antibiotic in various human tissues and body fluids. Nafcillin in therapeutic doses was administered pre-operatively to 212 patients undergoing major surgery over an 8-month period. Assignment of dose, route, and frequency of administration was randomized. At operation, specimens of serum and body fluids were obtained and tissue at operative site biopsied; 894 coded specimens were assayed by the cylinder plate technic.

Computer analysis of the data with conclusions and observations is presented in this exhibit.

Informational Exhibits

Exhibit Hours

9:00 a.m. — 5:00 p.m., Monday and Tuesday
9:00 a.m. — 3:00 p.m., Wednesday
May 17, 18, and 19, 1965

What's Your C.A.I.Q., Doctor?

WILLIAM J. FARLEY, M.D., Chairman; ROBERT E. JENNINGS, M.D., SAMUEL C. SOUTHARD, M.D., SEYMOUR CHARLES, M.D., Committee on Accident Prevention, New Jersey Chapter, American Academy of Pediatrics

The exhibit is designed to test the degree of sophistication of the practicing physician concerning his own experience and knowledge of accidental injuries by means of a blind quiz. It is based on a unique educational and fact-finding survey conducted through the cooperation of 125 New Jersey pediatricians and 33 of their affiliated hospitals during the month of April 1962. The significant findings of an analysis of 2,016 children treated in private practice and 6,684 children in the hospital emergency room provide answers to the questions: What is the most common injury in childhood? How many accidents do you treat each month? What proportions are fractures? dog bites? eye injuries? How many "stepped on a nail?" "Caught a finger in the door?" "hit by a car?" What part of the body is most frequently involved? What age is most vulnerable? How many do you hospitalize?

A summary report of this extensive study illustrated by graphs and charts will be provided in printed form for more detailed review.

Eye Health Screening in the Doctor's Office

SAMUEL M. DISKAN, M.D., Atlantic City

The exhibit shows how the general practitioner can do some simple eye screening tests in the office and gives basic information on what the general medical man should know about eye screening of his patients.

Programmed Instruction in Diabetes for Patient and Physician

ARTHUR KROSNICK, M.D., Diabetes Control Program, New Jersey State Department of Health, Trenton

The use of programmed instruction for self education of patients and physicians will be demonstrated. A course in normal and abnormal glucose metabolism will be available for use of viewers. A course on diabetes for diabetic patients will also be shown.

Disability Decision — Angina

EARL HOERNER, M.D., Senior Medical Officer, New Jersey Disability Determination Service, Newark

The exhibit is based on a study of medical evidence in 1500 cases involving arteriosclerotic heart disease. Revolving center panels specifically mention chest discomfort and its relation to activity, response to rest and nitroglycerin, prior infarctions, physical findings, chest films, ECG tracings, and limitations of functional capacity.

The Kessler Institute for Rehabilitation

HENRY H. KESSLER, M.D., Director, West Orange

This exhibit is to illustrate and describe the total rehabilitation program of the physically handicapped at the Kessler Institute for Rehabilitation, West Orange, New Jersey. Exhibited pictures will show various phases of: (1) The rehabilitation of the paraplegic; (2) The rehabilitation of the stroke patient; (3) The rehabilitation of the amputee.

There will also be printed material, describing in detail the work done at the Kessler Institue for Rehabilitation.

A Child Evaluation Center in a Community Hospital

CATHERINE E. SPEARS, M.D., ELIZABETH B. EKEN, M.D., Marristawn Memorial Hospital

The purpose of the exhibit is to demonstrate the function of a clinic within a general hospital, equipped to render truly complete evaluation of the child with problems of one sort or another.

The service was originally projected for the evaluation and assistance of the retarded, but with the development of its services it became apparent that these facilities would be as useful and as important to the normal child experiencing learning problems in the school situation, as well as to the adolescent burdened with more than the usual difficulties of a troubled time.

In the last three years of its functioning, the Unit has been available for all of these problems. The approach which is taken is based on the premise that all problems are best handled by a practical concrete approach, starting with the basic physical examination and progressing with the aid of complete laboratory studies—whatever may be needed—and the subsequent involvement of psychologists, neurologists, psychiatrists, and other specialized consultation services as deemed necessary. The very important social aspects of each of these problems are integrated through contact with our social workers and staff with educators, other treatment agencies, social agencies, the courts and members of the medical profession.

The end result and the recommendations which eventuate are discussed in a team conference at which all concerned parties are present.

The Society for the Relief of the Widows and Orphans of Medical Men of New Jersey

JAMES E. D. GARDAM, M.D., President, Belleville

The oldest society of its kind in this country presents an educational exhibit designed to acquaint physicians with the benefits to be derived from membership. The Society is a charitable organization, operated by physicians to provide relief for widows and orphans of deceased members. The exhibit consists of charts and educational literature.

The Academy of Medicine of New Jersey

JAMES E. D. GARDAM, M.D., Publicity Chairman, Belleville

The Academy of Medicine is the primary leader in Postgraduate Medical Education in the State of New Jersey. The exhibit outlines the functions of the Academy, which include the development of educational courses, symposia, and other scientific meetings; and, in addition, maintains the largest medical library in the State of New Jersey. The exhibit will provide an opportunity for physicians to become members of the Academy.

JEMPAC-AMPAC

JERSEY MEDICAL POLITICAL ACTION COMMITTEE, AMERICAN MEDICAL POLITICAL ACTION COMMITTEE

An audio-visual interview exhibit utilizing excerpts from a film "Political Wrap-Up." This exhibit utilizes tape with push button control. It is designed to educate the physician as to the proper and potential role of the physician on the political scene. It utilizes a bi-partisan approach.

Current Clinical Research at the National Institutes of Health

CLIFTON K. HIMMELSBACH, M.D., Natianal Institutes af Health, Bethesda, Md.

Exhibit is in the planning stage. It will depict selected current clinical studies for which patient referrals will be welcomed by the National Institutes of Health; and will explain the procedures for physicians to follow in referring patients to the Clinical Center and, by use of photographs and text, portray the Center's patient care facilities.

The World Medical Association

United States Committee, Inc.

The exhibit indicates programs and services offered to U. S. Committee members: observer privileges at WMA Assemblies; subscriptions to World Medical Journal and Newsletter—International News Items; international doctor-to-doctor book and journal program; overseas opportunities; index of international medical meetings; arrangements to visit foreign medical institutions; information, assistance, and travel arrangements specifically oriented for physicians. Featured are 80 color slides graphically portraying health and medicine around the world.

Radioactive Materials

EUGENE E. CIOFFI, M.D., Radiological Health, New Jersey State Department af Health, Trentan

Theme: Radioactive Materials — Dummy Radium Needles—Display Materials—Posters—Descriptive Materials.

Value of Early Diagnosis

JOSEPH I. ECHIKSON, M.D., American Cancer Society, New Jersey Divisian, Inc., Newark

The exhibit defines early diagnosis and the basis of curability of cancer. It uses three sites; namely, the uterine cervix, the breast, and the rectum, as examples.

It emphasizes the role that early diagnosis plays in cancer control and the need for emphasizing all available means to detect cancer while it is still in a curable stage.

EXHIBITS: YOUR THREE-WAY TREAT!

One of the colorful aspects of any medical convention is the array of exhibits. This year, your Society provides three classes of exhibits: Informational, Scientific, and Technical. Take the time to inspect all of them — not just a looksee and not a once-over-lightly scanning, either. But a real, indepth study. You'll be surprised how much you can learn.

Technical Exhibits

Exhibit Hours:

9:00 a.m.-5:00 p.m., Monday and Tuesday
9:00 a.m.-3:00 p.m., Wednesday
May 17, 18, and 19, 1965

Abbott Laboratories

Abbott representatives will be happy to answer any questions you may have concerning our leading products and new developments.

American Mutual Liability Insurance Co.

Mr. Joseph Britton, Manager, and Mr. Paul Stanton, Claim Manager, of the Professional Liability Insurance Department for New Jersey, will be pleased to answer any questions or discuss any problems relating to Professional Liability or Professional Premises Liability coverages.

Americana Corporation

Featured will be the new edition of the Encyclopedia Americana, which is available to delegates on an exhibit offer. Our representatives will be happy to show you the new major revision and explain any details.

Ayerst Laboratories

The Ayerst Laboratories' exhibit will feature Riopan Cookies, a new idea for the relief of hyperacidity, and Premarin Tablets with information on "New Concept of Treatment of the Menopause." Our representatives will discuss with you these products and any information you might desire on our other products.

Ayerst Laboratories

The Ayerst-BRL exhibit will feature Penbritin, a brand of Ampicillin. Penbritin is a synthetic broad-spectrum penicillin for wider use in major areas of infection. Our representatives will answer your questions and furnish you with additional information on this new product.

Baby Service, Inc.

A warm welcome and a red rose await each visitor at the Baby Service booth. This hospitality for over ten years has made Baby Service a conversation piece at every meeting. The latest improvement in diaper service for home and hospital will be on display. Ask about our new layette service for hospitals.

E. & W. Blanksteen Agency, Inc.

Information and literature regarding The Medical Society of New Jersey officially approved plans of income protection, major medical, life insurance and high limit accident insurance are available at this booth. More than 75% of the members of The Medical Society of New Jersey participate in one or more of these plans.

The Borden Company

The Borden exhibit has a surprise in store for you concerning Mull-Soy. We will also feature: Borden's hospital ready-to-feed infant formulas—the most complete line available—Bremil, Mull-Soy, Glucose, etc. Methakote, unique water washable antiseptic cream for diaper rash and cradle cap, and other dermatologicals Methatar, Methaphor, and Methaseptic.

Brookes Research Associates

Physician interviewing to determine experiences and opinions about problems of medical treatment in various areas.

Burroughs Wellcome & Co. (U.S.A.) Inc.

Information will be available on our products and the newest developments from the research facilities of Burroughs Wellcome & Co. Of particular interest at this meeting is current information on Actifed, for relief of respiratory congestion, and our analgesics including Ascodeen-30, the latest addition to our analgesic family of products.

Ciba Pharmaceutical Company

The exhibit will feature Esidrix® (hydrochlorothiazide Ciba). Ciba representatives will discuss the benefits of this product in hypertension (alone and as concomitant therapy) and in various edematous states (congestive heart failure, toxemia of pregnancy, premenstrual edema, edema of pregnancy, steroid-induced edema, edema of obesity, nephrosis).

The Coca-Cola Company

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of South Jersey, and The Coca-Cola Company.

Dome Chemicals, Inc.

Dome Chemicals Incorporated, world leader in dermatologicals, will feature dermatological specialties that are of general interest to the members of the Society. Topical steroid products as Cort-Dome®, Neo-Cort-Dome®, Domeform-HC®, Lida-Mantle-HC®, and Cor-Tar-Quin™ will be presented.

The Doyle Pharmaceutical Company

Have you tasted Meritene? Meritene is the good-tasting Protein-Vitamin-Mineral Food Supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Let us serve you a cool, refreshing Meritene Nourishment. Review also our Dietene Reducing Plan, designed to get better cooperation from over-weight patients. The Dietene Plan provides optimum nutrition and maximum satiety without the use of drugs. Meritene and Dietene are advertised only to the medical profession.

Eaton Laboratories

Since 1939, Eaton Laboratories has pioneered in the development of the nitrofurans, many of which have been available as legend drugs to the profession. Basic and clinical research is continuing on these as well as other classes of compounds. In addition, Eaton Laboratories offers a variety of research and educational services for all phases of medicine. The Eaton medical service representative welcomes the opportunity to

furnish you with complete information covering these services to you and the nitrofurans.

Thomas A. Edison Industries

Edison Voicewriter will show a complete line of business recording equipment designed to speed handling of medical paper work. Highlights: Edison Voicewriter executive models . . . for individual use by the doctor in his office and at home. Edison Escort . . . battery-operated portable dictating instrument. Envoy Compact . . . portable magnetic recorder. Televoice . . . phone network dictating systems for accurate, complete medical records in the hospital.

Encyclopaedia Britannica

Featured will be free descriptive literature on the great new edition of Britannica. Official delegates may now purchase this magnificent set at an offer only available at our convention exhibits.

E. Fougera and Company, Inc.

Valuable information on products in the specialties and general medicine, clinical trial material, and professional aids will be available. Please make special request of the booth attendant for other material which you may wish to receive.

Geigy Pharmaceuticals

The Geigy exhibit features important new therapeutic developments in the management of cardiovascular disease as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity, and other disorders, which may be discussed with representatives in attendance.

The Grolier Society, Inc.

The new Book of Knowledge, with over 50,000 entries, is often referred to as "the set my parents grew up with." Famous for over half a century, and endorsed by world leaders, the Book of Knowledge provides facts as they are needed in school work. Yet it also serves as background reading for all children.

Health Insurance Council

The Health Insurance Council is sponsoring a Coffee Lounge, and we look forward to the opportunity of meeting with New Jersey physicians during the meeting and hope to have much discussion on all subjects pertaining to private health insurance.

Johnson & Johnson

The Johnson & Johnson exhibits will feature the latest improvements in surgical dressings and professional specialty products as developed by the Johnson & Johnson Research Laboratories. The most recent advances for the practice of medicine include Surgicel Brand Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism; and Dermicel Brand Surgical Tape, a newly-improved special-purpose dressing tape for patients with unusual adhesive tape sensitivity, is an outstanding addition to a complete line of adhesive tape products. Well-informed representatives will be pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Kessler Associates, Inc.

Representative items for the self-care and management of the disabled are displayed with certified personnel in attendance to explain and describe their uses. The expansion of services has enabled us to move to a larger and more comfortable location to provide for all the needs of the amputee, hemiplegic, or other severely disabled patient. Free consultation for patient and home evaluation is available by our staff.

Knoll Pharmaceutical Company

Dilaudid ampules, multiple dose vials, and soluble tablets for prompt pain relief. Dilaudid Cough Syrup for persistant harrassing cough. Metrazol, Nice-Metrazol, Vita-Metrazol tablets and elixir for geriatric and convalescent patients. Quadrinal and Verequad tablets and suspension for relief of bronchospasm. Akineton for organic and drug induced parkinsonism.

Lamond Products, Inc.

The Lamond Dermatological Laboratories will introduce our newest product: Aquol, a significant advance in bath oils. We shall be glad to discuss Dermasorcin and Dermasul, Dermastringe, Bur-Zin, Bur-Cort, Bentical Shake Lotion, Sebana and Sebanatar, our recently introduced shampoos, Lamotane and Sunprotectol.

Lederle Laboratories

Lederle Laboratories has long been a leader in medical research and quality controlled production. Our sales representatives are prepared to discuss such products as Declomycin,® Aristocort,® Pathibamate,® as well as our numerous services to medicine, as they may apply to your practice.

David and Charles Levinson, Medical Specialties

David and Charles Levinson, Medical Specialties, will display the new Medco Sonlator Twin, and the Achilleometer, thyroid function test which needs no ECG. Also on display will be the famous Medcolater. The new concept in physical medicine is "Synchronized Sound and Stimulation." Ask us about it.

Eli Lilly and Company

Our sales representatives in attendance welcome your questions about Lilly products, and offer you precise information on recent therapeutic developments of Lilly research.

McNeil Laboratories, Inc.

Mr. Paul Lange is in charge of the McNeil exhibit. Products to be featured are: Butisol Sodium® butabarbital sodium, Parafon Forte,® and Tylenol® acetaminophen.

Mead Johnson Laboratories

Two important pharmaceuticals will be featured at the Mead Johnson exhibit: Vasodilan® (isoxsuprine hydrochloride), a myo-vascular relaxant, and Quibron® (theophylline-glyceryl guaiacolate), a bronchodilator.

Medical-Surgicol Plon of New Jersey

The Plan's booth will serve as an information center for Society members who have inquiries on Blue Shield policies, procedures, payments, or other matters. The rapidly changing dynamics of health care insurance—the increasing diversification of coverage by voluntary plans, the equation of protection to the medical economy, the impact of the socialized approach—make familiarity with his Society-sponsored plan of even greater import to the physician today.

Medi-Kol Physicians ond Hospitol Supply Co.

Medi-Kal this year will display the largest assortment of manual and hydraulic physicians examining tables ever to appear in one display area. There will be no less than four different types of electrically operated physicians examining tables, as well as several manual types.

Merck Shorp & Dohme

The theme of the Merck Sharp & Dohme exhibit is "Service to Medicine." One phase features the details of the Merck Sharp & Dohme Postgraduate Program. Another feature includes information on teaching films for use by the profession and, also, lay films that can be utilized to portray the story of medicine to the lay public. The exhibit is concluded with a display of finger-tip files on selected Merck Sharp & Dohme products.

Milex Products

Gyn specialties on display, the latest developments in uterine cancer detection will be discussed. A new concept in cervical therapy Amino-Cerv will be shown. "A Doctors Marital Guide for Patients," "A Doctor Discusses Menopause," "What Teenagers Want to Know," "A Doctor Discusses Pregnancy," "A Doctor Talks to 9 to 12 Year Olds," and "Personal Understanding of Marriage," all patient level educational materials will be available.

Morrissey-Halloron Associotes

The Bankers National Life Insurance Company of Montclair, N.J. and the Scudder Fund Distributors, Inc. of Boston, Mass. offer the Bankers-Scudder Profit-Sharing Plan for those physicians who would desire to take advantage of the new tax law by establishing a tax deductible retirement program under the Keogh (HR-10) legislation. The booth will be staffed by duly licensed representatives of Morrissey-Halloran Associates of Montclair, N.J.

Orgonon Inc.

The Organon Professional Service Representatives, under Peter Nicolett, welcome your questions and comments. The exhibit features Durabolin (nandrolone phenpropionate) which provides anabolic stimulation for a week from a single injection, Deca-Durabolin, (nandrolone decanoate) where the benefits of a single injection lasts 3 to 4 weeks, and Hexadrol (dexamethasone) in oral and injectable forms.

Ortho Phormaceuticol Corporation

Ortho® is proud to present the most complete line of medically accepted products for the control of conception. Of special note are the two latest products of the Ortho Research Foundation, Ortho-Novum® Tablets and Delfen® Vaginal Foam. Also on display will be our well-known products for treatment of various forms of vaginitis. Your questions will be welcomed by representatives in attendance.

Pfizer Loboratories

Professional Service Representatives from Pfizer Laboratories will be pleased to have you in attendance at their booth to discuss the latest products of Pfizer research.

Physicions Plonning Service Corp.

We are engaged in meeting certain financial needs of the medical profession. We make life insurance available on a deferred payment basis so that the physician does not have premium payments the first five years. We offer assistance in other financial fields, such as estate planning and financing of equipment and furniture.

The Purdue Frederick Company

Otalgine Drops, an anti-biotic, antifungal, anti-Inflammatory surfactant, is clinically effective in treating acute and chronic otitis externa and adjunctive acute and chronic otitis media and cleansing of post mastoidectomy cavities due to susceptible organisms.

Riker Loborotories

Representatives of Riker Laboratories will be glad to supply you with complete information concerning our products which are available to the medical profession. Please feel free to request answers to any questions you may have.

A. H. Robins Company, Inc.

The A. H. Robins Company representatives will be happy to answer any questions you may have about our products and explain their advantages.

Roche Loborotories

Librium® (chlordiazepoxide HCl) is a unique and versatile therapeutic agent which is virtually specific for the relief of tension.

J. B. Roerig ond Company

J. B. Roerig representatives will be in attendance to answer any questions you may have concerning their leading specialty products. Roerig recently introduced a number of new products, which representatives at the exhibit will be pleased to discuss with you.

Sandoz Pharmaceuticols

The Sandoz exhibit features Mellaril, Sansert, Cafergot

P-B, Fiorinal and Fiorinal with codeine. Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company

New Saunders books of special practical interest include: Current Therapy 1965; Edwards: Heart Disease; Gartland: Orthopaedics; Lamb: Electrocardiography and Vectorcardiography; and a new edition of the American Illustrated Medical Dictionary.

Schering Corporation

The Schering exhibit will feature new Celestone Soluspan. Representatives in attendance would be pleased to discuss its application with interested physicians.

G. D. Searle & Co.

The Searle representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Enovid for ovulation control and pregnancy and menstrual disturbances; and Flagyl, a potent, new trichomonacidal agent for trichomonal vaginitis, cervicitis, urethritis, and prostatitis.

Sherman Laboratories

More air for your asthmatic patients—faster—with Elixophyllin.® Sustained action: 24 hour bronchodilation with dosage q. 8 hr. Clinically proved by 30 published studies. Severe attacks terminated in 15 to 30 minutes. Get a plastic bottle for your bag at our booth. Reprints are also available—sent to your office on request.

Siemens Medical of America, Inc.

Siemens Medical will display the complete Siemens line. Different new developments for therapy and diagnosis will be shown, and our representatives will be on hand to answer any questions you may have. A few minutes at our booth may prove to be of great value to you.

Smith Kline & French Laboratories

Featured will be our new diuretic, Dyrenium (brand of triamterene). Representatives will be on hand to answer your specific questions and provide information on their products and services.

E. R. Squibb & Sons

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed. We will be pleased to present up-to-date information on these advances for your consideration.

William Allen Steadman & Company

William Allen Steadman & Company are the originators of complete financial service to the medical profession. This company is the investment adviser and the underwriter for Steadman Investment Fund, Inc. It is also the underwriter for Professional Service, Inc. These companies were organized at the request of a group of New Jersey physicians, in order to provide financial and investment assistance from internship through retirement.

Syntex Laboratories, Inc.

Synalar® (fluocinolone acetonide), the topical corticosteroid designed to meet specific dermatologic needs, will be featured. Synalar® has set a new standard of success in the treatment of a wide range of inflammatory dermatoses. Our representatives will discuss the latest developments from Syntex research.

Syntex Laboratories, Inc.

Norinyl® (Norethindrone 2.0 mg with mestranol 0.1 mg) Tablets, an original steroid from Syntex Laboratories, will be featured. Norinyl® 2 mg supersedes barrier methods of contraception. Complete information on this outstanding new product will be available.

U. S. Vitamin and Pharmaceutical Corp.

Arlidin will be on display, as well as other leading pharmaceutical specialties and nutritional products. Professional service representatives will be in attendance to welcome you and to be of help in answering any inquiries pertaining to the products on display, as well as any of their other products.

The Upjohn Company

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Wallace Laboratories

Our representatives will be pleased to furnish information regarding Wallace products and your related medical questions to assist you in your practice. Featured is our product Soma (carisoprodol).

The Warren-Teed Products Company

Featured products will be Kaon,® potassium therapy well tolerated and rapidly absorbed in GI tract (potassium gluconate in tablets and palatable elixir), and Chymolase Oral, a trypsinchymotrypsin tablet, containing 50,000 W-T units of proteolytic activity, for systemic therapy against trauma-induced inflammation and edema.

Westwood Pharmaceuticals

Westwood will feature their unique dermatological products: Fostex Cream, Fostex Cake, Sebucare, Sebutone, Sebulex, Fostril, Alpha-Keri, Keri Lotion. These products are particulary suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and sensitivities to soap.

White Laboratories, Inc.

White Laboratories' exhibit features an important prescription product—Disophrol Chronotab Tablets. Medical service representatives will be happy to discuss the many indications and the superior therapeutic effectiveness of this preparation.

OFFICES TO BE FILLED BY ELECTION

OFFICE	TERM	FROM TO	INCUMBENT and COUNTY
President-Elect	1 year	May 1965-May 1966	John J. Bedrick Hudson County
1st Vice-President	1 year	May 1965-May 1966	Joseph R. Jehl Passaic County
2nd Vice-President	1 year	May 1965-May 1966	Louis K. Collins Gloucester County
Secretary	1 year	May 1965-May 1966	Marcus H. Greifinger Essex County
Treasurer	1 year	May 1965-May 1966	Daniel F. Featherston Monmouth County
Trustees			
1st District	3 years	May 1965-May 1968	Nicholas A. Bertha Morris County
2nd District	3 years	May 1965-May 1968	Thomas C. DeCecio Bergen County
5th District	3 years	May 1965-May 1968	Carl N. Ware Cape May County
11th Trustee	3 years	May 1965-May 1968	Lloyd A. Hamilton[1] Hunterdon County
Judicial Councilors			
2nd District	3 years	May 1965-May 1968	John L. Olpp Bergen County
5th District	3 years	May 1965-May 1968	John S. Madara Salem County
AMA Delegates[2]			
	2 years	Jan. 1966-Dec. 1967	Joseph P. Donnelly Hudson County
	2 years	Jan. 1966-Dec. 1967	Isaac N. Patterson Gloucester County
	2 years	Jan. 1966-Dec. 1967	Jesse McCall Sussex County
	1½ years	May 1965-Dec. 1966	Frank J. Hughes[3] Camden County
AMA Alternate Delegates[4]			
	2 years	Jan. 1966-Dec. 1967	Joseph R. Jehl Passaic County
	2 years	Jan. 1966-Dec. 1967	John L. Olpp Bergen County
	2 years	Jan. 1966-Dec. 1967	Louis S. Wegryn Union County
	1½ years	May 1965-Dec. 1966	Matthew E. Boylan[5] Hudson County
	1½ years	May 1965-Dec. 1966	Jerome G. Kauman[6] Essex County
Delegates and Alternate Delegates to Other States			
New York Delegate	1 year	1966 Annual Meeting	William F. Costello Morris County
Alternate	1 year	1966 Annual Meeting	John W. Holland Atlantic County
Connecticut Delegate	1 year	1966 Annual Meeting	Lloyd A. Hamilton Hunterdon County
Alternate	1 year	1966 Annual Meeting	Josiah C. McCracken Atlantic County

[1] Third full term expiring; ineligible for re-election.
[2] With 6,039 members on 12/31/64, N.J. entitled to 1 more delegate—7 in all.
[3] Appointed by Board of Trustees for ½ year of 2 year term to fill new office for special session of AMA House in February 1965.
[4] With 6,039 members on 12/31/64, N. J. entitled to 1 more alternate delegate—7 in all.
[5] Appointed by Board of Trustees for ½ year of 2 year term to fill new office for special session of AMA House in February 1965.
[6] Appointed by Board of Trustees for ½ year of 2 year term to fill vacancy created by resignation of Dr. Hughes upon his appointment as Delegate.

Administrative Councils			
Legislation			
1st District	3 years	May 1965-May 1968	Ludwig L. Simon Essex County
4th District	3 years	May 1965-May 1968	William E. Bray Burlington County
Medical Services			
1st District	3 years	May 1965-May 1968	Francis J. Benz Morris County
6th Member	3 years	May 1965-May 1968	Frederick W. Durham Camden County
Public Health			
1st District	3 years	May 1965-May 1968	Edward E. P. Seidmon[7] Union County
4th District	3 years	May 1965-May 1968	Anthony P. DeSpirito Monmouth County
Public Relations			
1st District	3 years	May 1965-May 1968	S. William Kalb Essex County
6th Member	3 years	May 1965-May 1968	Howard C. Pieper Monmouth County
Standing Committees			
Annual Meeting	3 years	May 1965-May 1968	George J. Kohut Middlesex County
Finance and Budget	(members of 1965 House of Delegates)		
	3 years	May 1965-May 1968	Charles A. Landshof Hudson County
	2 years	May 1965-May 1967	John S. Van Mater[8] Middlesex County
Medical Defense and Insurance			
	3 years	May 1965-May 1968	William L. Palazzo Bergen County
Medical Education			
	3 years	May 1965-May 1968	Frank S. Forte Essex County
Publication			
	3 years	May 1965-May 1968	James J. Fitzpatrick Mercer County
Woman's Auxiliary Advisory			
	3 years	May 1965-May 1968	Ralph K. Bush Camden County

[7]Appointed by President for 1 year unexpired term of Estelle T. Milliser, M.D., resigned.
[8]Appointed by Board of Trustees for 1 year of 3 year term of Wayne H. Stewart, M.D., whose 1964 election was declared a nullity by the Parliamentarian—not a member of 1964 House.

GENERAL SESSION

Sunday, May 16, 1965, 3:00 p.m.

THE FUTURE OF ORGANIZED MEDICINE

James Z. Appel, M.D., President-Elect

American Medical Association

Members of The Medical Society of New Jersey and of the Woman's Auxiliary and their guests are cordially invited to attend this session.

Saturday-Tuesday
May 15-18, 1965
Chalfonte-Haddon Hall
Atlantic City

38th ANNUAL MEETING

Woman's Auxiliary to The Medical Society of New Jersey

Schedule of Events

Saturday, May 15, 1965

10:00 a.m. to 4:30 p.m.—Dinner-Dance tickets on sale at MSNJ Registration Desk (Lounge floor, Haddon Hall)

1:00 p.m. to 4:30 p.m.—Registration for Art Show (Lobby floor, Haddon Hall)

2:00 p.m.—Golden Merit Award Ceremony (Rutland Room, first floor, Haddon Hall)

Sunday, May 16, 1965

9:00 a.m. to 4:30 p.m.—Dinner-Dance tickets on sale at MSNJ Registration Desk (Lounge floor, Haddon Hall)

9:30 a.m. to 4:30 p.m.—Registration (Lobby floor, Haddon Hall)

10:00 a.m. to 4:30 p.m.—Special Events—Tickets on sale (Lobby floor, Haddon Hall) for: Annual President's Luncheon, Monday; Inaugural Buffet Luncheon, Tuesday (All doctors' wives invited)

10:00 a.m.—Exhibits (Lobby floor, Haddon Hall)—Art, County Press & Publicity Books, County Activities Pictorial Display

12:00 noon—Collation (Wedgwood II, Lounge floor, Haddon Hall)

12:30 p.m.—Pre-convention Board Meeting (Wedgwood II, Lounge floor, Haddon Hall)

3:00 p.m.—Tea and Fashion Show (Rutland Room, First floor, Haddon Hall)

6:00 p.m.—Fellowettes' Dinner (Derbyshire Room, Lounge floor, Haddon Hall)

Monday, May 17, 1965

8:15 a.m. to 9:00 a.m.—Collation (Room 134, First floor, Haddon Hall)

9:00 a.m. to 4:30 p.m.—Registration (Lobby floor, Haddon Hall)

9:00 a.m. to 4:30 p.m.—Special Events—Tickets on sale (Lobby floor, Haddon Hall) for: Annual President's Luncheon, Monday; Inaugural Buffet Luncheon, Tuesday (All doctors' wives invited)

9:00 a.m. to 4:30 p.m.—Dinner-Dance tickets on sale at MSNJ Registration Desk (Lounge floor, Haddon Hall)

9:00 a.m.—General Session (Rutland Room, First floor, Haddon Hall)

12:30 p.m.—Annual President's Luncheon (Carolina Room, Lounge floor, Chalfonte Hotel)

2:30 p.m.—General Session Reconvenes (Rutland Room, First floor, Haddon Hall)

7:00 p.m.—Dinner-Dance (Carolina Room, Lounge floor, Chalfonte Hotel)

Tuesday, May 18, 1965

9:00 a.m. to 10:00 a.m.—Collation (Wedgwood II, Lounge floor, Haddon Hall). County Presidents (1965-66) Briefing Session, Wedgwood II, Lounge floor, Haddon Hall)

9:00 a.m. to 12:30 p.m.—Special Events—Tickets on sale (Lobby floor, Haddon Hall) for: Inaugural Buffet Luncheon, Tuesday (All doctors' wives invited)

9:00 a.m. to 1:00 p.m.—Registration (Lobby floor, Haddon Hall)

10:30 a.m.—Postconvention Board Meeting (Wedgwood II, Lounge floor, Haddon Hall)

12:30 p.m.—Inaugural Buffet Luncheon (Rutland Room, First floor, Haddon Hall)

5:30 p.m.—Reception for MSNJ President-Elect Bedrick (Carolina Room, Lounge floor, Chalfonte) (All members invited)

Officers

President—Mrs. Philip J. Kunderman, Highland Park
President-elect—Mrs. Lewis C. Fritts, Somerville
First Vice-president—Mrs. Jesse T. Glazier, South Orange
Second Vice-president—Mrs. David E. Zuckerman, Paterson
Recording Secretary—Mrs. Edward A. Jasionowski, Parlin
Corresponding Secretary—Mrs. William Roe, Englewood
Treasurer—Mrs. Millard Cryder, Cape May Court House

Convention Committee

Chairman—Mrs. Samuel J. Kaman
Co-chairman—Mrs. Hugh Kearney

LETTERS TO THE JOURNAL

Sir:

Recently I had occasion to read a book called *Talent and Performance* by Ginzberg and his co-workers.* It has some meaning, I think, for medical education in New Jersey. Comparing the performance of Columbia students 10 to 15 years after graduation, Ginzberg finds that "Those who had graduated with honors, had won medals or prizes, had been elected to Phi Beta Kappa, were somewhat more likely to be in the *lower two achievement levels* than in the top level. Those who had been awarded a scholarship or other type of formal recognition for scholastic excellence and those who had been elected to an honorary academic societies were no more likely to be in the top achievement level than those who did not report any awards. Those who had received no undergraduate honors or distinctions of any type were more likely to be in the top achievement level than those who had been singled out for recognition."

The generalized type of Ivy League College training is found to be negative: ". . . large state or private institutions under religious sponsorship, or institutions which specialized in technical curricula, were more likely to be in the top achievement level."

The destructive effect of undirected training by educators concerned with training not only professional people but persons in the arts as well emerges in the following. "The school I attended (an Ivy League College) apparently considered its duties discharged upon the completion of my studies. I was cut adrift to fend for myself in a world which is not kind to those who possess a so-called 'liberal arts' education. As a broad intellectual base this education was fine. But for the pursuit of a definite career, and as an aid in earning my own living, this "training" was practically useless. And to a certain extent my college education was something of a hindrance, since it laid emphasis on the fact that "man does not live by bread alone." Unfortunately, I discovered late the importance of "bread" also—and found that for six years my college and graduate education had been protecting and sheltering me from the necessities of bread winning."

Ginzberg's study forcibly reminds us of the words Plutarch placed in Solon's mouth to warn Croesus of the Nemesis which would pursue his hubris. "The gods, O King, have given the Greeks all other gifts in moderate degree; and so our wisdom, too, is a cheerful and a homely, not a noble and kingly, wisdom." Ginzberg's data show that educators who abandon the Hellenic ideal of moderation may be merely urging their students into neurotic competition. Moreover, the claim to be able to pick out students of exceptional merit turns out to be empty pretense. An expression of disdain for mediocrity may thus be viewed as an intention to arrogate for oneself a seat of authority which may not, in fact, exist. Ginzberg found that professors often gave unfavorable recommendations to persons who later turned out to be productive. "We found letters of recommendations written about the respondents, mostly by their professors in graduate school, which we compared with their later performance. Those who had been rated by their teachers as having above average abilities do not show up disproportionately in the top achievement level." . . . An interesting sidelight on these professorial evaluations is the fact that men who were considered by their teachers to be 'colorless' were much more likely to be in the lower achievement level than those whose personalities had been assessed as 'unattractive."

Pretension is inevitably offensive; but when pretension is coupled with a dog-in-the-manger attitude, it is necessary for society to examine the potential damage which a proud and positive educator can wreak upon our

* The book is published by the Columbia University Press, New York City.

much-needed manpower potential. Excellence and superiority, unlike maturity, are not quanta to be measured independently of circumstances. A student is excellent or poor only with regard to particular sets of circumstances. Moreover, success is a difficult accomplishment to measure and one which has such a strong subjective component that any objective evaluation is bound to fall short of its most significant boundaries. One of the most significant factors favoring development and success is what Ginzberg calls the "reality situation"—social demand for the kind of training the person is trying to market. Viewed in such a light, a proper attitude toward medical training in New Jersey would be a common sense, forthright fulfillment of existing and foreseeable social needs rather than the pretentious formulation of arbitrary standards to achieve what must remain a poorly comprehended, if not quite imaginary, professional élite. What we need is a considerable number of matter-of-fact young doctors going about the tasks which simply are not going to get done if these very sensible people are not there.

Fred A. Mettler, M.D.
Blairstown

Dear Mr. Editor:

The following item, distributed by the AMA at the recent Congress on Mental Illness, will interest all your readers:

By their very nature, the management of emotional conflict and mental illness is a complex matter. The basic and natural sciences still have a wealth of material to yield before we can issue a confident prognosis. And yet, even though knowledge of the mental disorders is imperfect and incomplete, we are only using a fraction of what we already know about prevention and treatment.

There are many reasons for this inefficient use of current knowledge. One is the overwhelmingly diversified array of factors which contribute to mental illness. Respected researchers and practitioners have reached no clear concensus to clarify basic questions of etiology, and debate flourishes on the relative influence of biochemical, environmental, organic, and functional factors.

We cannot, however, afford to sit back and wait for the smoke to clear and the answers to come. Mental illness is too prevalent and pervasive an entity. We have sufficient knowledge, tools and techniques to make significant progress in lessening the ravages of mental illness.

However, if this goal is to be achieved, we must have support from all physicians, regardless of specialty, plus the services of skilled non-medical personnel. Present knowledge coupled with early, comprehensive treatment can cope with the vast majority of the mentally ill. There is a shortage of manpower in the psychiatric field. Physicians can be a tremendous help in overcoming this manpower shortage—not by becoming quasi-psychiatrists, but simply by incorporating sound psychiatric principles within the framework of their everyday practice. No matter what his specialty, a beneficial psychotherapeutic influence is an essential and desirable part of every physician's relationship with his patients.

More than half the patients seen by the family physician are troubled by ailments with emotional as well as physical components. By increasing his skill in matters affecting the psyche, the physician better serves his patient and adds an important dimension to the practice of preventive medicine.

J. Lloyd Morrow, M.D.
Passaic

ANNOUNCEMENTS

Academy Meetings

Announcement is made of the following meetings of the Academy of Medicine of New Jersey.

Tuesday, April 20, at 12 noon. *Pancreatic Carcinoma.* Riverview Hospital, Red Bank

Wednesday, April 21, at 8:30 p.m. *Hormonal Therapy of Acne.* Hotel Suburban, East Orange.

Thursday, April 22, at 1:30 p.m. *The Hypochondriac and the Pain-Prone Patient.* St. Clare's Hospital, Denville.

Thursday, April 22, at 8 p.m. *Hospital Teaching Problems.* Academy Building, 317 Belleville Avenue, Bloomfield.

Tuesday, April 27, at 8:30 p.m. *Perinatal Mortality.* Memorial Hospital, Newton, N.J.

Wednesday, May 5, at 8 p.m. *Skin Manifestations of Intestinal Disease.* Microbiology Institute (Rutgers) New Brunswick.

Hemolytic Disease of the Newborn

On Thursday evening, May 13, there will be a symposium on hemolytic disease of the newborn. The colloquium will be held at 20 Hudson Place in Hoboken, which is the local office of the Community Blood Bank sponsoring the meeting. Several nationally known experts will be on hand to answer your questions. For exact time and program, write to the Administrator, Community Blood Bank at 20 Hudson Place, Hoboken.

Chemotherapy Conference in Philadelphia

June 16 is the day, and Philadelphia's Drake Hotel the place for an all-day conference on chemotherapy and hormone therapy in cancer. A star-studded faculty has been recruited and a lively discussion is promised. For more details, write to American Cancer Society at 623 Central Avenue, Newark 07107.

New Pathology Diplomates

Four New Jersey physicians have been certified by the American Board of Pathology, so far in 1965. They are Dr. Sheldon Lang of Newark, Dr. Kenneth Lee of Camden, Dr. Alfonso Madrazo of Jersey City, and Dr. Sandra Wolman of Morristown.

Blood Bankers To Meet in Florida

The American Association of Blood Banks will hold its next technical session in Bal Harbour, Florida. An exceptionally interesting and immediately usable program has developed. The dates are September 14 to September 17. For more details, write to the American Association of Blood Banks at 30 North Michigan Avenue, Chicago 60602.

Medical World News

The 19th World Medical Assembly will convene in London September 19 to 25, 1965 under the auspices of the British Medical Association. The major scientific subject will be "Transmission of Communicable Diseases and International Travel." The social program, particularly for the ladies, will abound in special excursions and visits to places of interest.

In conjunction with the 19th World Medical Assembly, prepared Pre-Assembly and Post Assembly study tours have been arranged by the United States Committee Travel Depart-

ment. If you want to visit countries not included in the program of tours (or if you do *not* wish to travel with an organized group) itineraries will be tailor-made to your requirements as to places and means of transportation. Substantial savings will result with no curtailment of service. Fourteen to 48-day tours to Ireland, Africa, Great Britian, Asia, and any where in Europe (including Russia) are planned.

When a physician joins the World Medical Association he also becomes a member of its United States Committee. If he attends the 19th Assembly in London, he officially becomes a U.S. Observer.

For additional information on hotel accommodations, travel, medical visits, sightseeing, and registration forms, write to:

United States Committee Travel Dept.
The World Medical Association
10 Columbus Circle
New York, New York 10019

Additional information will be available at the Exhibit Booth of the World Medical Association in the Educational Section during the Annual Meeting of The Medical Society of New Jersey in Haddon Hall, Atlantic City May 15 to 19.

Henry A. Brodkin, M.D., Essex
Travel Representative for London, W.M.A.

ROOM RESERVATIONS

Complete and mail this form for your room reservation

199TH ANNUAL MEETING—THE MEDICAL SOCIETY OF NEW JERSEY

May 15-19, 1965

Reservation Oesk, Chalfonte-Haddon Hall, Atlantic City, New Jersey

Please reserve the following accommodations on the European Plan ( ) Modified American Plan ( ) American Plan ( )
Add $7.50 per day per person Add $9.00 per day per person

No. of Rooms	ROOMS WITH BATH		HAOOON HALL (Meeting Hdqts.)	CHALFONTE (Across Street)
	Single	For One Person	$10.00 ( ) $12.00 ( ) $14.00 ( )	$ 9.00 ( ) $11.00 ( )
	Oouble (Twin Beds) without ocean view	For Two Persons	$14.00 ( ) $16.00 ( ) $18.00 ( )	$12.00 ( ) $14.00 ( )
	Double (Twin Beds) side ocean view	For Two Persons	$19.00 ( ) $21.00 ( ) $23.00 ( )	$16.00 ( ) $19.00 ( )
	Oouble (Twin Beds) ocean front	For Two Persons	$27.00 ( ) $30.00 ( )	$19.00 ( ) $21.00 ( ) $23.00 ( )
	Oouble Room and Parlor ocean front		$57.00 ( )	
	Oouble Room and Parlor side ocean view		$42.00 ( ) $44.00 ( )	
	Oouble Room and Parlor without ocean view		$36.00 ( )	

Each Additional Person in Oouble Room $4.00 European Plan, $11.50 Modified American Plan, $13.00 American Plan.

I will share a room with .....

Expect to arrive .....**Oepart** .....

Name .....

Address .....

This reservation will be acknowledged. Please arrange to double up when possible—single rooms are limited.
NOTE: As check-out hour is 3:00 p.m., rooms may not be ready earlier.

BOOK REVIEWS

Counseling in Medical Genetics. By Sheldon C. Reed, Ph.D. Philadelphia and London, 1963, Saunders Company. Pp. 231, plus appendix. Ed. 2. ($5.50)

The book opens a completely new vista on a subject with which we all have had some contact and have had an opportunity to use in clinical practice. But this may be accompanied by the dispensing of misinformation on our part. This book deals mainly with the functioning, activities, and origins of the Dight Institute for human genetics in Minneapolis. At this installation, all counseling is done free. The book includes a roster of other institutes performing a similar function. They deal mainly with individuals who have problems regarding the advisability of having more children after having one previously abnormal child, or who are subject to heredity disease and inquire about the possibilities of their contracting or transmitting an affliction to the next generation. As is often stated in the book, the likelihood is usually less than the individual imagines. All that the institute can do is give the applicant the odds for or against transmission of a trait in accordance with Mendelian Law and statistical analysis.

I have found the book interesting, and I intend to obtain it for my personal library. During the short time that I have had it on my desk, I have been able to use it as a reference in answer to patients who want to know the odds or the chances of their transmitting a specific disorder.

EDWARD N. COMANDO, M.D.

Current Practice in Orthopedic Surgery. By J. P. Adams, M.D. St. Louis, 1963, C. V. Mosby Company. Pp. 217, Illus. ($12.75)

This book is a crystallization of contemporary orthopedic concepts and research. It is divided into three sections.

In the section on "Orthopedic Surgery," Dr. Allen discusses "The Challenge of Spina Bifida Cystica." He points out that good management includes preventing complications, particularly urinary tract infection, trophic ulcerations, and contractures. Methods for accomplishing this are reviewed in terms of correcting deformity and promoting functional activity. Prophylactic correction is aided by a chart of deformity predictability based on lesion level. Procedures for the prevention and correction of deformity are described.

"Physiologic Approach to Lumbar Intervertebral Disc Derangement," by Dr. Feffer, describes recent research in the anatomy, physiology, and biomechanics of discs and the vertebral bony structure. The author questions the traditional concept of etiology, diagnosis, and treatment of low back pain. A therapeutic regimen is outlined, but this by no means excludes laminectomy where conservative treatment fails.

Section III (Miscellaneous) includes Dr. C. Wise's "Electrodiagnosis in Orthopedic Practice." Electromyography is the only objective measurement of the neuromuscular mechanism, but its use is limited because of apparatus complexity and paucity of trained interpreters. Drs. Albert and Schuster's article, "Blood Volume," dramatically reviews components of blood, its distribution and its reservoir areas. A discussion of the "Psychiatric Aspects of Orthopedics," written by Dr. Yochelson, encompasses consideration of patients' environment (home-hospital), pre-illness or accident personality, his ability to tolerate dependent apprehensive situations, patient transference, and counter transference of those attending him. Alertness to patient's communications (direct, lucid, symbolic, or unwitting) will cue and prepare the physician to reassure and counsel objectively. Included are some valuable tips on recognizing some of the more masked needs and conflicts of the patient.

JOSEPH ADAMCIK, M.D.

Synopsis of Ophthalmology. By William H. Havener, M.D. St. Louis, 1963, Mosby. Ed. 2. Pp. 394 with 249 illustrations. ($7.85)

Dr. Havener has reduced the bulk of the material to the minimum and grouped it around the most practical eye problems faced by general practitioners. Such chapters as "Diagnosis and Management of Red Eye," "Meaning of Eye Symptoms," "Value of Consultation and Referral" make this book unique in arrangement of the content and in handling the material. Index and glossary help the reader find detailed reference to a single disease or question in the practical classification.

The material is up to date and includes such problems as "differences of opinion" between optometrists and Ophthalmologists and "blindness is preventable."

The printing and illustrations are clear. The language is simple. This pocket size book is a friend of students, teachers, and general practitioners. For more detailed elaboration, full size textbook is needed.

BELA SZINEGH, M.D.

Medical Personnel in World War II. By Office of The Surgeon General of the Army. Washington, D.C., 1963, Government Printing Office. Pp. 548 with 68 tabulations and 40 illustrations. ($6)

Snafu has become the traditional epithet to hurl at Army administration. Nobody seems to pay attention to the enormous job the Department of Defense had to do during World War II, and the astonishingly successful and effective way they did it. Take the medical department, for instance. In 1941, this department had 130,000 officers and men. By 1945 this had zoomed to 700,000. Somehow they were recruited, oriented, fed, clothed, housed, transported and assigned. And the medical department, unlike most of the other services, had to staff itself almost entirely from civilian sources —there was no West Point of medicine and no Officer Candidate Schools in the colleges to provide a source. Not only that, but The Surgeon General had no control over procurement, classification, promotion, or assignment, though he was responsible for the whole department. And just to make it more complicated, the high command had to deal with 48,000 uniformed

physicians—an occupational group not noted for its docility, conformity, or fondness for paper work.

This volume tells how they did it. It reviews the needs of the Army, the problems of recruitment, the role of the ancillary corps, the utilization of personnel, and the headaches associated with redeployment, training, promotion, pay, and duty assignments. Morale factors are discussed, too. Suprisingly enough for an official Government document, the editors pull no punches in pin-pointing sources of dissatisfaction within the Army or in criticizing what they think was wrong. While this text is not recommended as light bed-time reading, it is a valuable addition to our little library of experience. If the time comes again when so vast an expansion of the medical department is needed in so short a time, a study of this book will light-up some right and wrong ways of doing things. Perhaps, not. Perhaps every generation will have to make its own mistakes.

HENRY A. DAVIDSON, M.D.

Occupational Health and Mantalent Development. By Robert Collier Page, M.D. Illinois, 1963, Physicians Records Company. Pp. 680. ($18.50)

Page, in his new book on *Occupational Health and Mantalent Development,* has written a medical primer for industry. This comprehensive work covers all aspects of occupational medicine, illuminating not only the progress already made in this field but, even more important, the new and exciting possibilities of controlled preventive health care.

Page rightly regards industry as contributing to a progressive revolution in controlled medical care as well as being a fertile field for the study of human illnesses, human reactions, and human psychology. Nowhere is this more evident than the concern of industry to protect their heavy investment in high level manpower. With this has come the ever increasing growth of executive health programs. To explore all factors which contribute to or affect individual productivity, company programs have gone far beyond the primary physical examination and have actually become physical re-educational programs. The application of preventive medicine on an annual basis gives to each individual a silent partner, the doctor; and it is growingly apparent that the continued partnership between medicine and industry determines in large measure the quality, performance, and, therefore, the survival and success of management groups.

This book is an outstanding contribution to medicine's effort to improve the health and environment of the working man and outlines in clear and concise terms the unlimited horizons of human engineering.

ROBERT B. MARIN, M.D.

Proceedings of the June 1963 Conference of Professional and Scientific Societies. Commission on Drug Safety, 221 N. La Salle Street, Chicago 1, Illinois. Pp. 179. (No price given)

These proceedings consist of a number of papers by authorities in clinical pharmacology, drug research, and industry as well as in the Food and Drug Administration and academic medicine. The publication was directed by the Commission on Drug Safety. The conference reviews the activities of the professional and scientific organizations in meeting the problems of drug safety. An overview is afforded of a whole range of problems confronting the pharmaceutical industry and research.

The commission on Drug Safety was established in August, 1962, and its first activity was to provide authoritative consultation on the new regulations of the Food and Drug Administration which were proposed almost immediately after the Commission's formation. This book is easily read and is of special interest to physicians, administrators, and researchers associated directly or indirectly with the pharmaceutical industry. It is useful for medical directors of pharmaceutical companies, but of limited value to practicing physicians.

HAROLD S. FELDMAN, M.D.

Medical State Board Questions and Answers. By H. F. Flippin, M.D. Ed. 10. Philadelphia, 1963, W. B. Saunders and Company. Pp. 508. ($9.50)

For more than half a century this book has been a concise *vade mecum* for the medical student and for the new physician preparing for a State Board examination. Advances in medicine are recorded here and the text is thoroughly up to date. The volume is divided into the traditional sections: anatomy, pharmacology, surgery, jurisprudence, preventive medicine, and so on. It is presented entirely in question and answer form, so that there is, inevitably, a jumping around from one idea to another. Some of the other "state board" books try to present material in straight monographs and thus become, in effect, textbook outlines. Dr. Flippin's approach more closely simulates what the examinee will face when he comes to take his "boards." The answers are short, compact, and, necessarily, somewhat dogmatic. Some of them are of the "discuss" or "comment upon" variety which, of course, lends itself to "opinion" replies; but this, too, is realistic. Some examinations are designed that way. There are no illustrations, but the index is exceptionally well prepared. More and more states are now using multiple choice examinations, and this guide is especially useful in laying foundation for answering this type of question. All in all, these 500 pages pack in an enormous amount of medical information.

PIRI RONALD, M.D.

Mental Mechanisms. By Henry P. Laughlin, M.D. Washington, D.C., 1963, Butterworths, Inc. Pp. 262. ($7.50)

In this slim work, Dr. Laughlin reviews six major mental mechanisms: compensation, identification, inversion, repression, restitution, and sublimation. The *modus operandi* and the practical utility of each is briefly described and the text then is made to spring into life by a rich variety of actual cases illustrating resort to the mechanism. As the author points out, these dynamisms are foundation blocks of psychopathology and therefore an essential basis for psychotherapy. Many other mechanisms are briefly described. The book will prove a useful tool to clinicians in all medical specialties, to apprentice psychiatrists studying for Board examinations and to teachers, psychologists, social workers and others interested in human dynamics.

FELIX A. UCKO, M.D.

Campbell's Operative Orthopedics. Edited by A. H. Crenshaw, M.D. (With 21 contributors.) St. Louis, 1963, Mosby. Two volumes. Pp. 1778, with 1535 illustrations. Fourth edition. ($57.50)

Since 1939, this work has been the bible of the orthopedic surgeon. It has satisfied the needs of the student as well as the requirements of the busy practitioner. It is also a valuable aid in the fields of general, plastic, and traumatic surgery. This monumental text is obviously not the work of one, or even several researchers. Most of the authors are associated with the Campbell clinic (Memphis, Tennessee) and the University of Tennessee College of Medicine. The other contributors are recognized authorities from various parts of the United States and Europe. Each chapter is followed by an extensive list of references. The effort and years of time spent in compiling this exhaustive work is quite apparent.

The differences noted between this fourth and prior editions mirror the trend in orthopedics today. Modern advances in diagnostic technics and surgical applications are responsible for emphasis on the surgical treatment, for example, of cerebral palsy, scoliosis, and tumorous conditions. Considerable space has been devoted to arthroplasty, especially of the rheumatoid joint. This is due to skills gained in the use of recent chemotherapeutic agents, and also to a change in viewpoint which previously regarded this condition primarily as a non-surgical disorder.

The effect of antibiotics in recent times has made possible more and varied types of surgical procedures in osteomyelitis. This conceptual reorientation in tuberculosis has been brought about by anti-tuberculous drugs. The result of Salk and Sabin vaccine is apparent in the decreased discussion of the treatment of the condition. Another emphasis is in the field of industrial trauma, amputation, and prosthesis.

These volumes represent for practical purposes the most extensive and up-to-date surgical reference for the orthopedic surgeon of today. Joseph Bellino, M.D.

Patient Care and Special Procedures in X-Ray Technology. Vennes Watson. Mosby, 1964, St. Louis.

This book fills a void in certain procedures on sterile technic missing from the usual material in books on radiographic technology. It should have a place in every school of technicians as an introduction to the field of x-ray technology.

The emphasis on sterile technics and the references in nursing procedures are well contained and specific. The need for this type of data for the training technician has been well recognized in this edition and the book should be well received by the training school. For the young man or woman considering a career in the field of x-ray technology, this well presented text should be an inspiration. The advanced material on the more recent procedures of cardiovascular radiographic, television and cine radiography will furnish a basis for practicing technicians and lead to further study. This practical introduction to radiographic technology will be appreciated by instructors. It deserves a place on the shelf in all x-ray departments training technicians.

The paragraph covering professional organizations, has no real place in a reference book such as this; it sounds like salesmanship on a highly controversial basis. This should be deleted in the next edition. In general, however, this book is a definite asset to x-ray technicians. Frank Antonacci, ASRT

Care of the Rheumatoid Hand. By Adrian Flatt, M.D. St. Louis, 1963, Mosby. Pp. 222 with 102 illustrations. ($11.50)

This is an expanded version of the 1962 Hunterian lecture to the Royal College of Surgeons. Dr. Flatt says that this monograph is a balanced assessment of conservative and surgical measures. Actually it is a plea for early surgical intervention. The removal of the villous synovia and the reconstructive surgical procedures are beautifully described. Prostheses with ingenious hinges are demonstrated. The models and x-rays show how in the hands of a competent orthopedic surgeon—which Dr. Flatt is—reconstruction of the hand and fingers can be accomplished. Case reports are presented. Stress of the importance of both physical and occupational therapy, pre and postoperatively, is made. Sets of exercises with complete instructions are outlined. This monograph is easily read. The x-rays, photographs, and models aid in maintaining good continuity.

This book is good for the practitioner of rheumatic diseases but is a *must* for the orthopedic surgeon interested in the "Care of the Rheumatoid Hand."

H. H. Tillis, M.D.

Current Pediatric Therapy. By S. S. Gellis, M.D. and B. M. Kagan, M.D. Philadelphia, 1964, Saunders. Pp. 747. ($16)

Two outstanding pediatricians have agglomerated some comprehensive but many trivial observations by 250 physicians into a vast collection of over 300 articles relative to pediatric illnesses. There is little evidence of discrimination in the editing. Surely, neither of the editors is as casual in the use of chloramphenicol as many of the authors seem to be. Nor can I accept that they believe, as does Dr. Parrott, that "clinical (sic) meningoencephalitis occurs in 10 per cent of mumps cases." In the chapter on asthma the use of aminophyllin is stressed. Having seen deaths and near-deaths on several occasions from this drug, not only from over-dosage but from apparent hypersensitivity, this reviewer regrets the inclusion of Tedral® as a medication of choice. A number of rare clinical entities are included which defy all therapeutic approach. Conditions that require specialized surgical care are treated with a lick and a promise that is of help neither to the casual reader nor to the trained individual to whom, perforce, they must be referred. At the same time, some common entities, such as cutaneous hemangiomas and metatarsus adductus, are not included. The chapters on hemorrhagic diseases by Hilgartner and Carl Smith, on acute poisoning by Lucas and Imrie, and rheumatic fever by Grossman and Dorfman are excellent, Dr. Goldbloom's consideration of nasopharyngitis and the tonsil and adenoid problem is worth the price of admission—if only more would take heed. For the treatment of neonatal tetany, the authors advise a dose of calcium chloride that is double that suggested by most authorities. I have known of a severe reaction following the administration of so considerable an amount of calcium chloride.

Let us hope that in the next edition, there may be fewer subjects, more references, and—perhaps—a greater editorial and content contribution by Dr. Gellis and Dr. Kagan. Meanwhile, if one lacks an adequate reference library, this book is worth acquiring.

George Heller, M.D.

Alcohol and Civilization. Edited by S. P. Lucia, M.D. Pp. 416. Soft binding. New York, 1963, McGraw Hill. ($3.95)

"Any substance," writes Dr. Lucia, "which has had continuous use in all civilizations from the earliest history to the present has, in its own right, achieved a validity which places it among the truly cultural attributes of history." The substance, in this case, is alcohol. And this is a book in praise of it. It is a transcript of a symposium held at the University of California. In addition to Dr. Lucia (who edited the volume), some 20 others contributed to the symposium. Ten were physicians.

Alcohol is praised as (1) a factor in eliminating unfit genes, (2) a civilizing influence on over-anxious and irritable husbands, (3) a good servant to humanity, (4) an efficient body fuel, (5) a medicinally valuable sedative, (6) a diuretic, (7) a stimulator of gastric secretion, (8) a safe replacement of fats as a source of calories, (9) an aid in recovery from chronic illness, (10) a help in "shifting gears between the workaday world and private life," (11) a saviour of marriages, (12) a clarifying factor in business decisions, (13) a sign of sophistication, (14) an expediter in getting acquainted, (15) an important factor in human mate selection, (16) a carrier of culture and the refinements of civilization, and (17) a source of inspiration to poets. In reading all this, the reviewer found the pages coming apart in his hands: this was due to a wretched job of binding, and not to taking the symposium's advice too seriously.

The symposium was supported by the California Wine Advisory Board. GEORGE B. SHARBAUGH, M.D.

Strategies of Psychotheraphy. By Jay Haley. New York, 1963, Grune and Stratton. Pp. 204. (No price listed)

While intended primarily for doctors who do psychotherapy, this book is interesting to any practitioner. After all, an emotional component intervenes between any physician and his patient regardless of the doctor's specialty. Mr. Haley visualizes this relationship as a struggle for control. As he sees it, the doctor must always remain "one up" on the patient. He realizes that the patient, however, is also struggling to control the situation: while he comes to the doctor for help he still does not like the idea that he is to be passive putty in the doctor's hands.

The text gives numerous examples of how patients try to assert their control and how doctors seek to take the reins away from them. One way the doctor can maintain control is to tell the patient to do what he wants to do anyway. If the patient obeys, he is doing what the doctor has told him to do. Mr. Haley is not a psychiatrist, not a psychologist, but a communications analyst. He thus sees psychotherapy—and indeed, all doctor-patient relationships—as essentially a problem in communication.

Surely there is a good deal more to psychotherapy than a struggle for control. However, this "control" aspect has been little written about. Mr. Haley's book will arouse interest and suggest some novel approaches for the practitioner. ABRAHAM LEFF, M.D.

Elementary Medical Statistics. By Donald Mainland, M.D. Philadelphia, 1963, Saunders. Pp. 381. Ed. 2. ($9.00)

Most of us are too sophisticated to accept experimental results based on impressions, subjective reactions, or clinical intuition. In this era of advancing pharmacology, the experimenter or promoter of a drug or other treatment technic, has to show, mathematically, that the findings could not have been the result of chance. Some twelve years ago, Dr. Mainland produced the first edition of his *Elementary Medical Statistics*. The book was well received and the current volume offers, in many chapters, a novel presentation of the material. The first half of the book consists of questions, to which the answers constitute a working text in statistics. Dr. Mainland asks—or assumes that you will ask—such questions as: How do you obtain samples? What do you do when the statistics show that your findings are not significant? What does *significant* mean anyway? How do you know what the chance distribution would have been? The second part of the book is a standard statistical text. The physician cannot grasp it by just casual dipping into the volume. It takes a little study, a little working through of the examples given. However, no doctor these days rushes into a print with an observation that has not been statisticaly validated. And in seeking such validation, Mainland can help.

VICTOR HUBERMAN, M.D.

Care of the Geriatric Patient. Edited by E. V. Cowdry, Ph.D. Ed. 2. St. Louis, 1963, Mosby. Pp. 566. ($11.85)

In 1958, the first edition of this book was released and won an immediate following as a pioneer anthology of geriatrics. This second edition has been enlarged, and its clinical focus sharpened so that there is less emphasis on the detailed pathology of tissue changes and more on the every-day problems of the medical practitioner. Some 29 different authorities (only 18 of them physicians) have contributed. The text covers all the specialties—cardiology, psychiatry, surgery, urology, orthopedics, anesthesiology, dermatology, and dentistry. There is an excellent chapter on the maintenance of continuity of medical responsibility in caring for an aging patient. Nursing home problems are reviewed, and also included is a treatise on home care programs and another on rehabilitation.

As with all anthologies, there is considerable variation in the clarity and usefulness of the various chapters. All in all, however, this is a handy book to have in the library of any general practitioner, urologist, or doctor whose practice includes many elderly patients.

ULYSSES FRANK, M.D.

Emergency Treatment and Management. Thomas Flint, Jr., M.D. Philadelphia, 1964, Saunders. Edition 3. ($8.75)

During the past decade, *Flint, On Emergencies,* has become accepted as the ready reference Bible for emergency rooms, first-aid squads, ambulances, and factory infirmaries. After all, in an emergency no doctor has the leisure to browse through a library. This flexibly-bound book can be kept in the doctor's bag or even in the glove compartment of the car. It can really be a friend in need. FLORENCE OBUCHOWSKI, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

April, 1965 • Vol. XXXVIII, No. 4

SMOKING AND RESPIRATORY DISEASE

While the causal relationship between smoking and chronic obstructive lung disease has not been established, the evidence at hand incriminates cigarette smoking in the development of chronic bronchitis, frequently the fore-runner of irreversible lung disease.

Cigarette smoking, and to a lesser extent other forms of tobacco smoking, are generally agreed to be associated with mortality from lung cancer. The question is whether there is a cause-effect relationship.

If there is merit to the hypothesis that cigarette smoke, by its effect on the epithelial defenses of the respiratory tract, provides a local environment for carcinogens, it would be meaningful to find that there is an association between lung cancer and chronic nonspecific respiratory disease (asthma, chronic bronchitis, obstructive pulmonary emphysema).

Certain epidemiologic similarities between lung cancer and chronic nonspecific respiratory diseases may be noted from mortality statistics. Both have shown an epidemic increase in Canada, the United States, and England and Wales. Both have a similar urban-rural differential mortality and a predilection for men and for persons in middle age.

Relative Risks of RD

The most widely reported prospective studies of smoking have demonstrated that the relative risk of death from the chronic nonspecific respiratory diseases is many times higher in cigarette smokers than in nonsmokers.

Population surveys of chronic nonspecific respiratory disease prevalence have contributed to our knowledge of the relationship of these diseases to current cigarette smoking. Through a standard questionnaire and simple pulmonary function tests, chronic respiratory disease can be identified and classified, and related to other variables under study.

In the 1961 survey of Berlin, N.H., the prevalence of chronic bronchitis was found to increase consistently in men and women with increasing cigarette smoking habits up to a five-fold increase for those smoking more than two packs a day. Similar smoking-intensity gradients of disease were noted for the signs and symptoms of more severe obstructive lung disease.

A number of geographic comparisons of chronic respiratory disease prevalence indicate that differences in population smoking habits parallel differences in disease prevalence. The situation is not so simple. In the Berlin survey the combined effect of *age* and current *cigarette-smoking intensity* was found to have a significant relation to chronic bronchitis and obstructive lung disease. This was observed in men, not in women.

Age-smoking intensity specific rates should probably be used in geographic comparisons, though even this may be inadequate because of observed geographic differences in practices of inhalation and length of cigarette smoked.

Donald O. Anderson, M.D., *American Journal of Public Health*, November, 1964.

The respiratory disease prevalence in Berlin was recently compared with that in a small rural town, Chilliwack, British Columbia. The prevalence of chronic bronchitis in men 25 to 74 was only 21.5 per cent at Chilliwack compared to about 30 per cent at Berlin. When age and cigarette-smoking intensity were simultaneously taken into account, the observed prevalences of chronic bronchitis and obstructive lung disease in Chilliwack were not found to be significantly different from those predicted from the experience at Berlin. Thus, for these two populations surveyed in a similar manner and by the same workers, the urban-rural gradient for the chronic nonspecific respiratory diseases in men can be explained by age and smoking differences.

Age and Smoking Factors

This overwhelming contribution of age and smoking to the prevalence of chronic nonspecific respiratory disease can obliterate a less powerful effect of another variable in studies of small samples. Perhaps a smoker so pollutes the air which enters his tracheobronchial tree that the biological effects of other sources of pollution are not readily apparent.

The question arises whether simple bronchitis is really a disease. Can such a condition, which affects 20 to 40 per cent of the adult American population, be of much pathologic significance? Most persons who have chronic bronchitis and who smoke either lose their bronchitis or have a marked reduction in their daily phlegm when they stop smoking.

This chronic productive cough is related to pathophysiologic changes in the tracheobronchial tree—tobacco smoke interferes with ciliary action, slows the flow of the mucous blanket, and changes the consistency of the mucus. Smoking has been shown to be associated with a hypertrophy of the bronchial mucous glands with cellular abnormalities in the tracheobronchial epithelium which appear to decrease when smoking stops; some cellular changes, however, appear to be related to age, sex, and residence (urban and rural), as well as to cigarette smoking habits.

Though many studies of cigarette inhalation have failed to show any effect on mechanical factors of respiration in healthy subjects, in a recent study, a 25 to 30 per cent decrease in airway conductance has been reported immediately after inhalation of cigarette smoke; this bronchoconstriction occurs similarly in both smokers and nonsmokers, is rapidly reversible and recurs after a second cigarette. The inhalation of a pharmacologically inert submicronic particle can produce this reaction, which is likely mediated through the vagus nerve.

The evidence points to the fact that smoking is the most important, though not the only, factor in the production of simple bronchitis, and that with time bronchial obstruction is produced; initially this obstruction is probably reversible, but with further exposure more serious irreversible obstructive disease of the lung is produced.

From the epidemiologic study at Berlin, it was found that the point at which the relative risk of chronic bronchitis and obstructive lung disease doubled in smokers over that of those who had never smoked cigarettes was somewhere between 3,000 and 6,000 packs of lifetime smoking. This is the equivalent of eight years of smoking at the rate of a pack a day.

At the moment, epidemiologic, pathologic, and physiologic evidence incriminates cigarette smoking in the production of chronic bronchitis, though not solely so, for nonsmokers also have this disease.

What should be the public health action to deal with bronchitis? Certainly, control of air pollution will contribute somewhat. But bronchitis is clearly related to another form of air pollution which is self-induced—tobacco smoking. It seems inefficient to plan an effective control program which does not attack the practice of cigarette smoking first.

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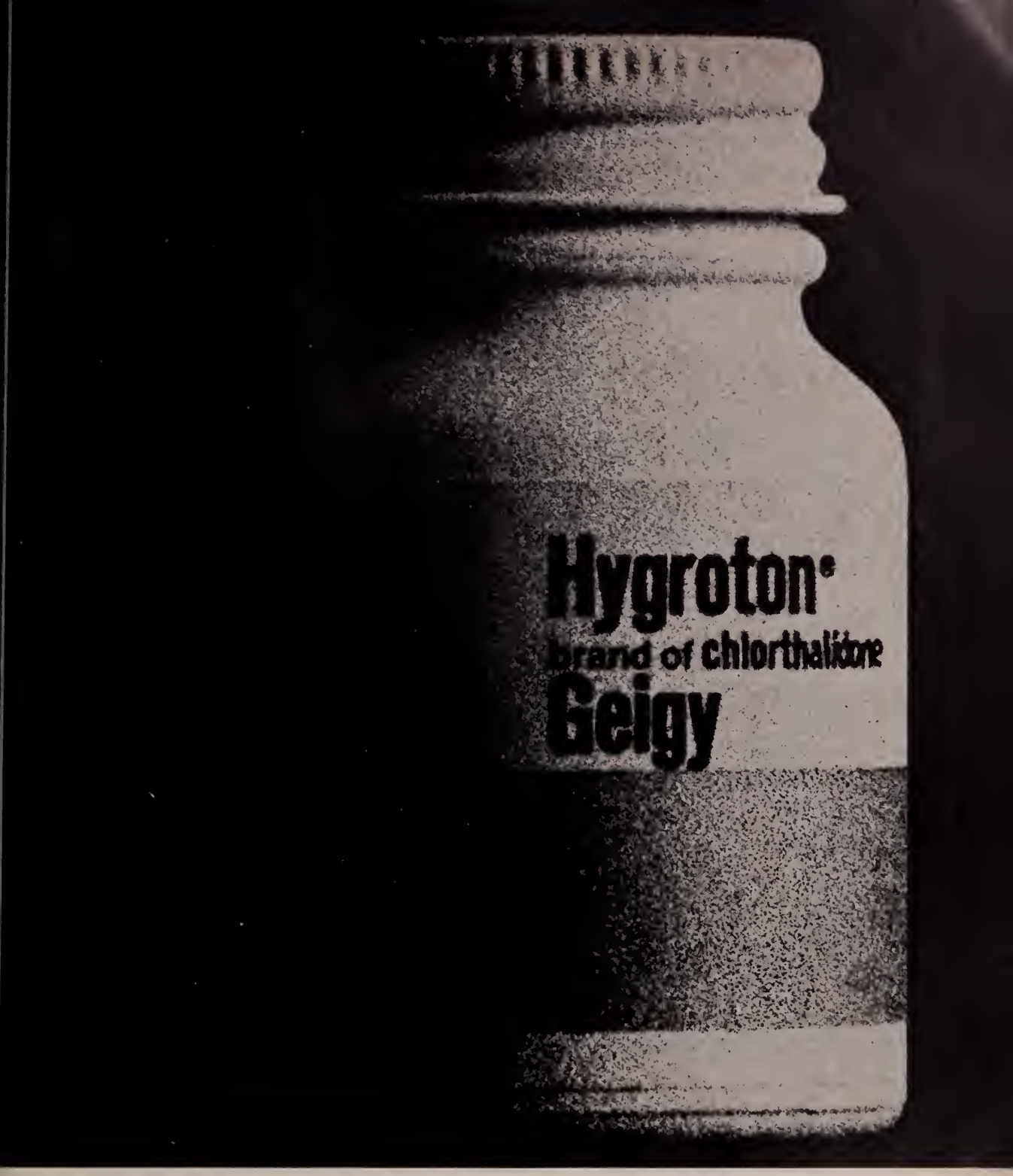
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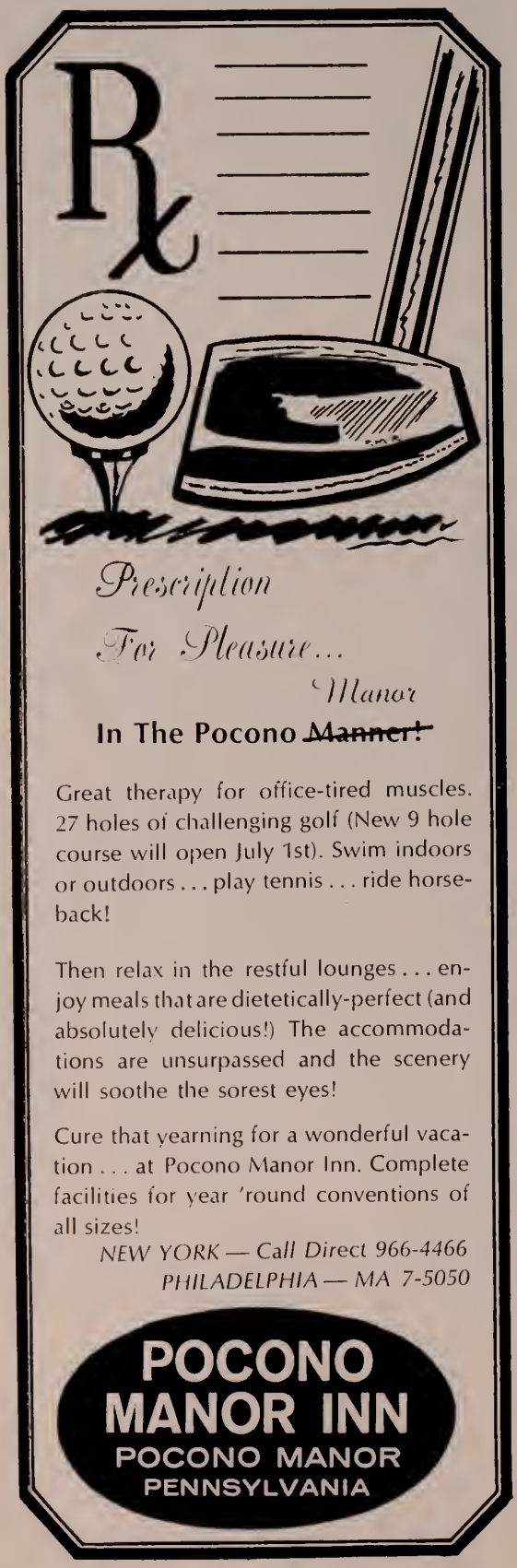
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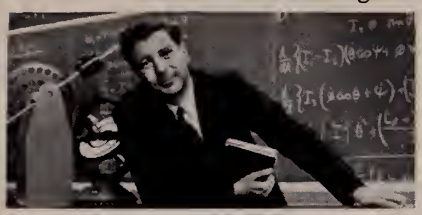
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1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press 243:578 (June 29) 1960.

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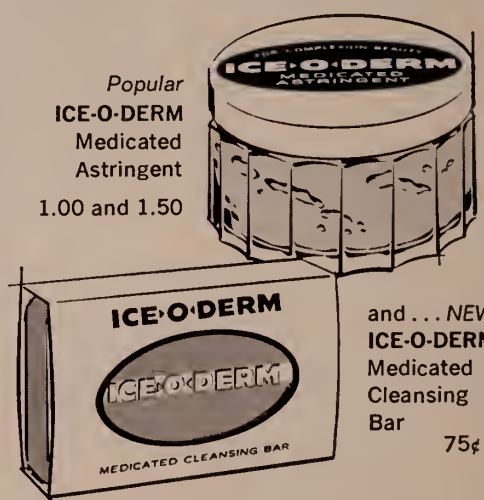
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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

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*Swartz, C., et al.: Circulation 28:1042, 1963.

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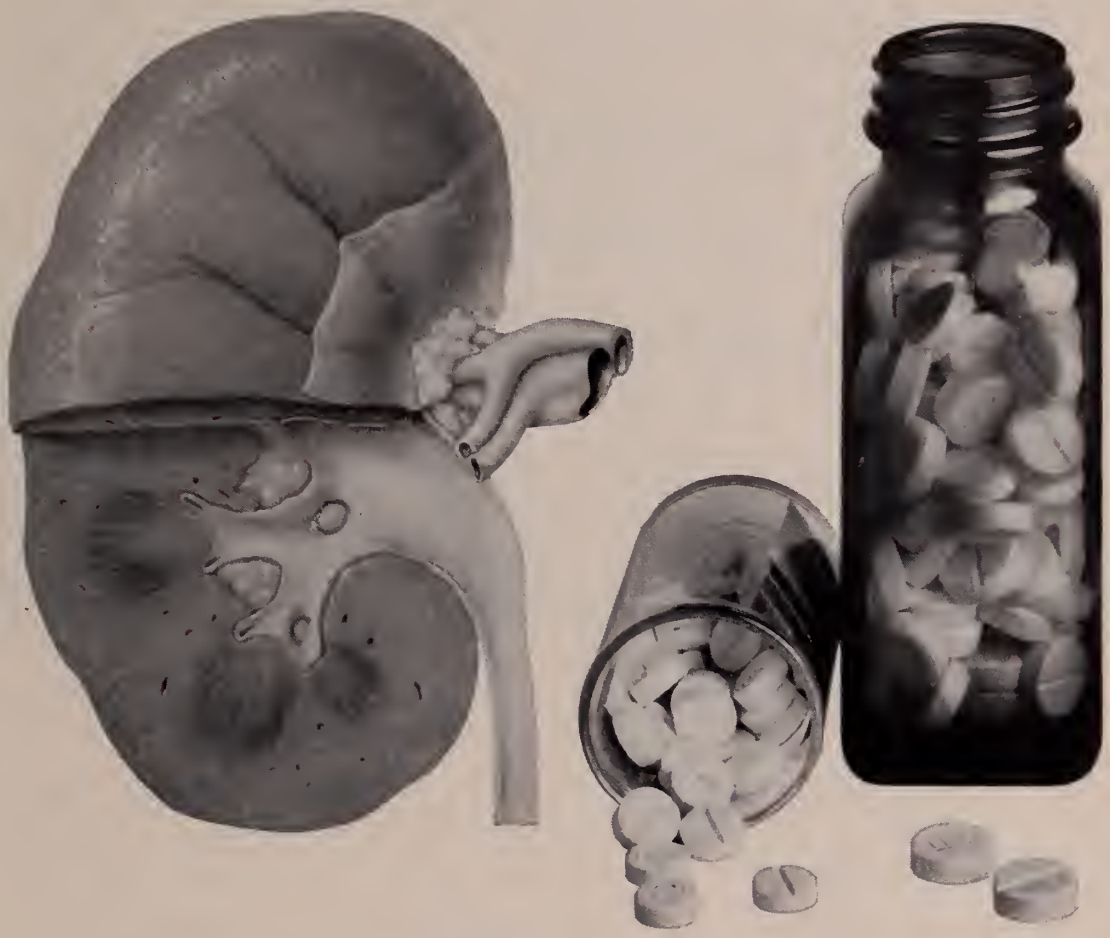
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1. Beaser, S. B.: J.A.M.A. 187:887, 1964. 2. Marble, A.: Appl. Therap. 5:614, 1963. 3. Moss, J. M. et al.: Med. Times 92:645, 1964. 4. Linder, M. et al.: New York St. J. Med. 62:337, 1962.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
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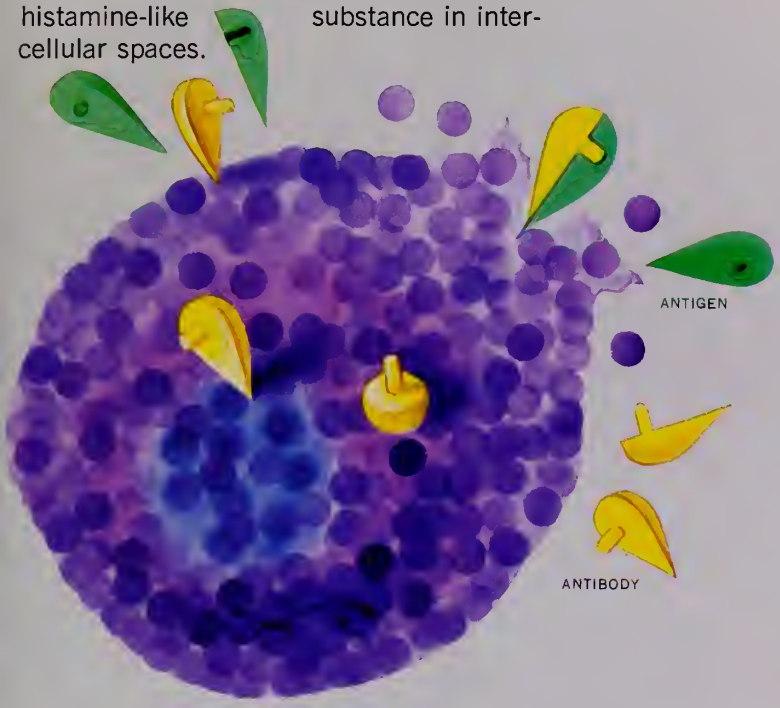
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*Schiller, I.W. and Lowell, F.C.: New England J. Med. *261*:478, 1959.

BRIEF SUMMARY: *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness. *Side Effects:* Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Other dosage forms available:* conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

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REFERENCES: 1. Soto-Hall, R.: Med. Sci. *14*:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See Medical News: J.A.M.A. *185*:39 (July 13), 1963. 3. Gordon, E.J.: Med. World News *5*:54, 1964. 4. Cozen, L.: GP *26*:82, 1962. 5. Larson, C.B.: Postgrad. Med. *26*:142, 1959. 6. Forsyth, H.F.: J.A.M.A. *167*:163, 1958. 7. Weiss, M., and Weiss, S.: J. Amer. Osteopath. Ass. *62*:142, 1962. 8. Rowe, M.L.: J. Occup. Med. *2*:219, 1960.

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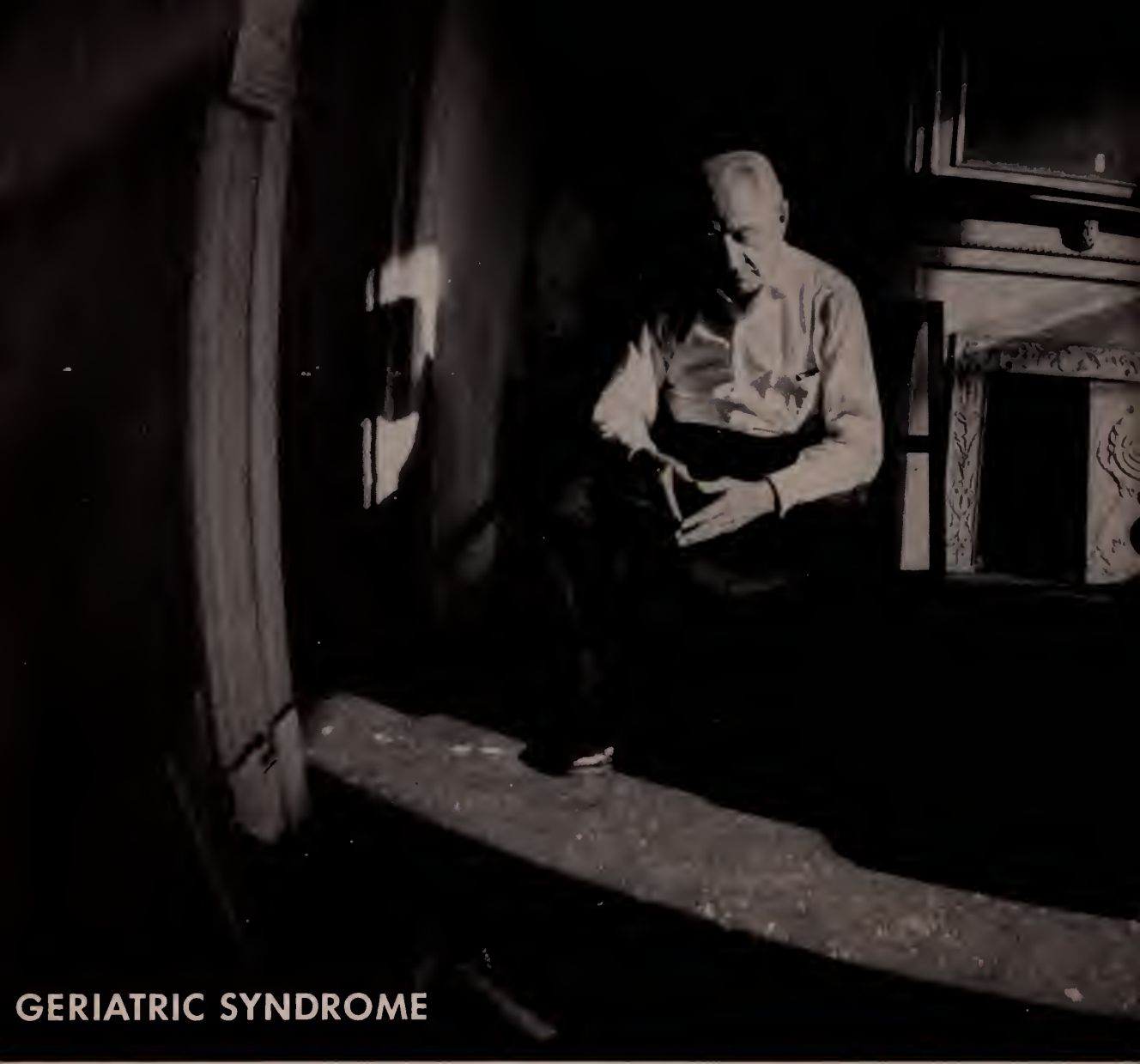
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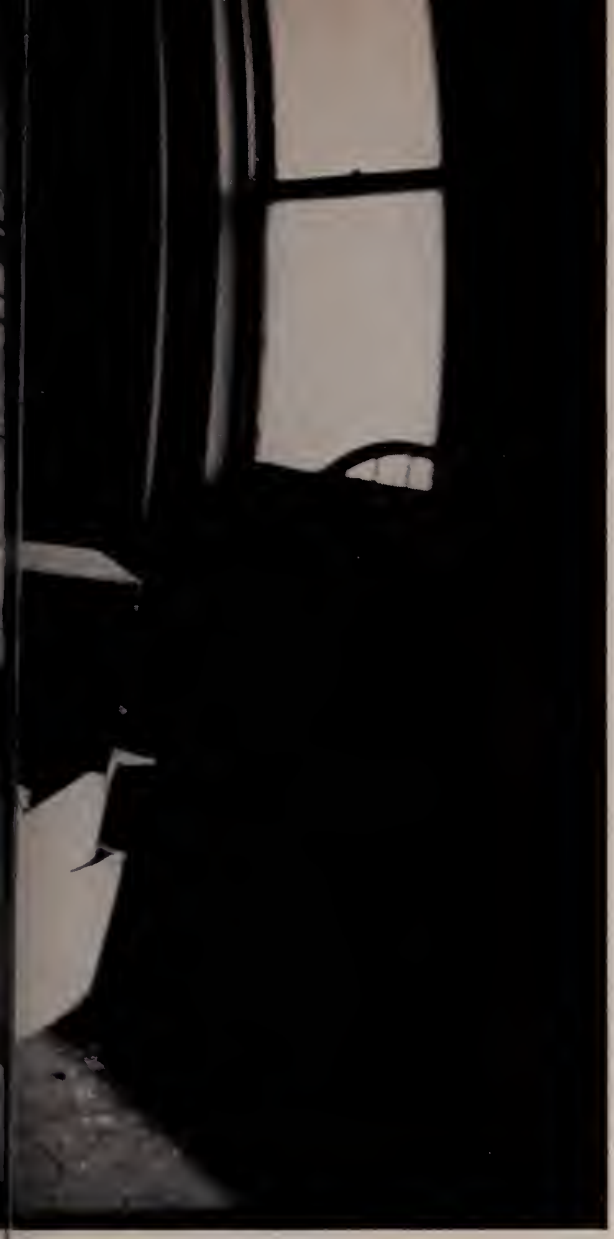
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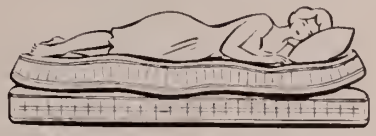
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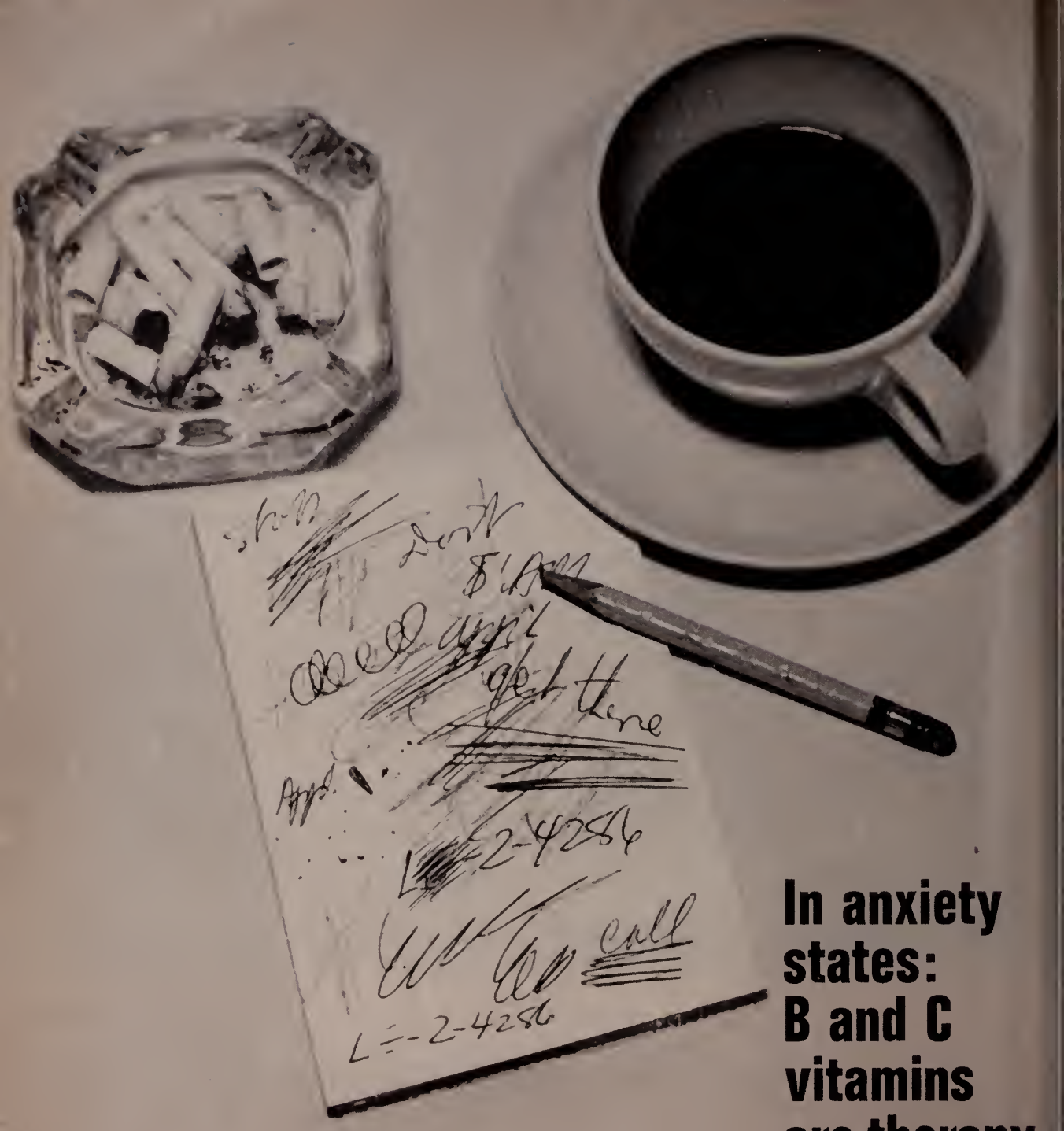
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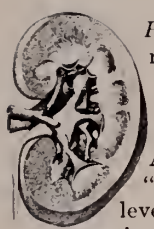
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EDITORIALS

The Cosmopolitan Air

It has always been one of the special glories of our profession that it knows no barriers of nationality, political conviction, race, religion, or citizenship. We think we have the best medicine in the world, right here in the U.S.A. Lots of foreign physicians must think so, too, since they flock here for advanced education, training, internships, residencies, and practice. But we must not become smug in the thought that we know it all. We don't. The rest of the world has a lot to teach us, and many first-rate physicians live outside the U.S.A. A cosmopolitan air is, indeed, most appropriate.

And it is fitting that the 114th AMA convention in New York this month will have a wholesome international flavor. The AMA has scheduled eminent foreign physicians to deliver lectures at the scientific meetings to be held during the convention.

American physicians will have an opportunity at the New York convention to mingle with doctors from throughout the world and to learn of current medical knowledge in other lands.

The six general scientific meetings of the convention will offer the latest research developments in adverse drug reactions, organ transplantation, hearing, non-narcotic drug addiction, metabolism in growth development and aging, and diagnostic cytology.

When doctors pour in from all over the world, it would be absurd for any physician right next door (yes, we mean New Jersey) to stay away.

It's all one world, medically speaking. Here's your chance to absorb some of the cosmopolitan style. Go to the AMA convention this month.

Short-Selling the Community Hospital

The larger any organization gets, the greater the propensity towards dehumanization and bureaucracy. This is not a matter of individual malice. No one wants to impair the comfortable camaraderie of a pleasant one-to-one human relationship. It is simply that this is a built-in defect of vast organizations. An employer of six or seven people can play the role of a friendly father to his handful of employees—all of them, in a sense, co-workers. But you can't run General Motors or the University of California on the buddy system.

This highlights one of the problems of the huge medical center. Here and there a traditional doctor-patient relationship may flourish in such an institution, but for the most part, the patient misses the closeness and intimacy which characterizes the small community hospital. And in view of the strong emotional tincture in so many diseases, this lack may actually impair his recovery. The professional staffs, too, show the effect of bureaucratic channelling. Ideally, in a structure like a hospital, the physicians should know each other and work together in harmony. In a hospital staffed by 75 or 150 doctors, this is quite possible. But in a medical center with interns, residents, students, technicians, and staff personnel measured in the hundreds upon hundreds, this is as unlikely as establishing a fellow-feeling among all Chevrolet owners.

One by-product of this is the staff's temptation to admit and retain patients in terms of their interest to the doctors, their usefulness for research studies, or their service as teaching material. (The very word "material" here gives the show away.) This is bound to dilute interest in the patient's medical progress and personal contentment. It is almost as if the purpose of the institution were being reversed. Originally, it was the function of the hospital to help sick people get better. But the huge medical center may unwittingly find itself thinking of the patient as research or teaching material. This is not a mistake that

a small, community-based hospital will make. Surely it should be the purpose of leaders of medical education to improve medical-care standards in community hospitals by helping such institutions—not by abolishing them, or sneering at them, or destroying public confidence in them, or by making it hard for them to get staff. Medicine's basic purpose (treating people who are sick) has long been well served in community hospitals.

Omit Your Narcotic Number

Next time you have prescription blanks printed, omit your narcotic registry number. In fact, if you have a large supply of such blanks now on hand, you might do well to have new—and numberless ones—printed. This may seem like odd advice when, for many decades, doctors have been urged to use their narcotic registry numbers . . . but there's a reason. Inspectors are picking up forged prescription blanks in various parts of the state — prescriptions calling for narcotics or barbiturates. Obviously, every pharmacist can't know the signature of every M.D. in New Jersey. But if there were no printed registry number, the thief might not know that such a number is required; and the pharmacist, seeing no number, would be alerted that something was wrong. Or, if the thief wrote in a number, it would be the wrong one, and confirm the fact that the form was forged.

There is, of course, a more basic prevention than that. Don't leave Rx blanks on your desk top; don't use them for bridge score pads, scrap paper, or notes to the milkman. It takes only a blink of the eye for a handy "patient" to tear off a few sheets when your back is momentarily turned.

If you use numberless blanks, remember to ink in your R Number when you write for a narcotic.

This request is made at the recommendation of the Board of Trustees of The Medical Society of New Jersey. It's wise advice: heed it!

The Humane Uses Of Chemical Warfare

According to the New York *Times,** our Army is involved in research into biologic and chemical warfare. Among the biologic agents now being studied for their military possibilities are botulism, anthrax, and tularemia. Such is the progress of medical science that it is now possible, they tell us, to produce infection *via* aerosols which could be wafted over enemy territory. A brand new scientific discipline is about to born: aerobiology.

The chemical rather than the biologic possibilities sound like something out of science fiction. An Army publication, identified as Pamphlet 3-2 (1960) notes (says the *Times**) that "troops exposed to one of these agents were not even conscious of their abnormal condition, which was so changed that they were unable to follow simple commands and perform normal tasks." The idea is that chemical warfare will be considered non-destructive and humane, because it will drug, stupefy, nauseate, and prostrate the enemy without killing him. Lysergic acid derivatives are now being studied with the hope that this might produce hallucinatory experiences or disorientation in enemy troops. One Army spokesman is quoted by the *Times** as saying that the ideal mixture "would bring happily intoxicated enemy troops into our lines humming the Star Spangled Banner with their hands up."

At first it may seem somehow improper to divert medical skills into such researches. But then, the Hippocratic Oath pledges us simply to "exercise our art solely for the benefit of our patients;" so even if the enemy troops be considered patients, we are acting for their benefit by bringing them happily out of the trenches. Anyway, says section 5 of our *Principles of Ethics,* "A Physician may choose whom he will serve."

Tranquilizers march on, and it is not surprising that they eventually will find a place in war. Here, at least, is one way to bring peace through tranquility.

* Issue of November 22, 1964

ORIGINAL ARTICLES

Many have sung a premature requiem for the general practitioner. Here, our President shows why he is sure that family doctors, like old soldiers, will never die.

Some Thoughts on and for the General Practitioner*

Charles H. Calvin, M.D./Perth Amboy

Many melancholy seers today regard general practitioners as members of a vanishing breed. And, indeed, recent statistics do reflect the progressive reduction of the number of general practitioners in our country, as more and more young doctors defect or are deflected to the fields of specialty practice.

I have only one reason that keeps strong in me the conviction that, like the poor, the general practitioner will always be with us. That is the fact that the good and the need of the patient make the general practitioner indispensable.

I think it was Voltaire who said "If there were no God, it would be necessary for men to invent one." Paraphrasing Voltaire, I contend, "If there were no general practitioners, it would be necessary to invent them." Let me briefly tell you why.

First of all sick people, by and large, must place themselves and their very lives in the hands of a trustworthy practitioner in whom they have full confidence. In order that such full confidence may be theirs, they must know and esteem that practitioner as a person. They must have the encouraging consciousness that he knows and esteems them as persons and is dedicated to serve their best interests as persons and as members of whole families of other persons whom he knows and cares for.

For long years one of the bitterest consequences of being sent to jail was that in jail one became depersonalized. He became a number and lost his name. He was despoiled of recognition and consideration as a person. He became lost in the faceless ranks of the imprisoned. But this fate was his by way of punishment. He wasn't expected to like it, and he wasn't expected to pay for it. But patients are not prisoners or felons. They have not lost their rights to human dignity and personal satisfaction. Patients are people, and they must be treated as such if they are to respond and to be satisfied.

So I am convinced—despite the present wave of automation and depersonalization in the

* Presented January 1, 1965 at the annual meeting of the New Jersey Chapter of the American Academy of General Practice in Atlantic City.

name of superficial efficiency—that if the true good and the total well-being of patients continue to be served by the medical profession of this nation, the demand for the personalized service of the personal and family physician will continue. That type of service may be experimentally diminishing for a while, but it will re-emerge by popular demand. When better personal, professional medical care is rendered, mark my words, the personal physician—the general practitioner—will be identified with it.

The progressive depersonalization of medical care is freighted with the threat of as great a loss to the purveyors of medical care as to its recipients. If the one who renders professional service to the patient is a hyper-technician who does perform his specialized service and gives way to a succession of other hyper-technicians in the course of a patient's life, the individual physician will be as little known and as fleetingly remembered as any other accidental acquaintance that the patient may make. He will find no lasting place in the gratefulness or recollection of those whom he has impersonally and transiently served. Thus, he will lose one of the most treasured compensations of medical practice—the continuing gratitude of his patients for long years of valuable services, and a warm and honored place in their hearts and in their lives. His only reward will be the fees he collects—a poor substitute for the affection and sympathetic interest of his fellowmen.

Brief, impersonalized service of this type also places in jeopardy another important human satisfaction: popular recognition of professional competence. The specialist's collective accomplishments—garnered through services rendered to a wide succession of patients who are not in contact with him long enough to get to know him, or be known by him, in a personal way—the sum of his fame, will be known only to his fellow specialists and colleagues. This situation may be adequate prestige-wise, but it makes for a sense of lonely separation from the warm-hearted men, women, and children who would gladly have honored him as a person if they had had the chance to know him as such.

Over and above all these considerations, family doctors are necessary to make proper, prompt, and most efficient use of the services of specialists. In the absence of family doctors to whom people can go to find out what is wrong with them and what special professional care—if any—they need, people will have to resort to self-diagnosis . . . a practice to which good medicine must always be opposed as incompatible with the good of the patient and tremendously hazardous to his health and life. Apart from the hazards of delay and danger to the patient who needs immediate and precise treatment, the haphazard drifting of patient from specialist to specialist in the endeavor to find the one who can help him adds tremendously—and unnecessarily—to the costs of medical care for such patients.

So, I conceive that family physicians—general practitioners—are and will continue to be necessary both to the people and to the profession of medicine. It is our task not to be discouraged by passing experimental drifts, but to rely confidently on the nature and needs of people and the profession, and to continue to serve them both to the best of our abilities, and to encourage others to join us in that dedication.

Through a lifetime of service in this type of personalized medical practice, I have found genuine satisfaction and reward as a physician and as a man. I urge all of you not to be disheartened by changing times and theories.

The nature of man is constant and his basic needs unvarying. When it comes to sickness, man needs the help that the family physician alone can fully supply or make promptly available. Therein lies our security. Therein will lie the security and satisfaction of generations of family practitioners who will follow us, as long as we do not lose faith in ourselves or relax in our goal everyday to do our job as well and as satisfactorily and as *personally* as we can.

80 Commerce Street

When troches were laced with antibiotics, the residual nasopharyngeal inflammation disappeared earlier than it did in subjects who took lozenges containing only aminobenzoate.

The Antibiotic Effectiveness of Oral Troche Therapy*

James J. Fitzpatrick, M.D.
Rafael Mederos, M.D. / **Trenton**

The efficacy of antibiotic-containing troches in influencing the bacterial flora during episodes of acute pharangitis has been uncertain. These lozenges are often used on an empirical basis if they are available without prescription. The purpose of this study is to determine if there is a significant difference in pharyngeal flora of patients with upper respiratory infections who are treated with antibiotic-impregnated troches, compared to those receiving a placebo troche.

We administered a troche containing ethyl aminobenzoate (tradenamed Benzocaine), neomycin sulfate, and gramicidin. The identical-appearing placebo-control contained only the aminobenzoate without the two antibiotics. The double-blind technic was followed, with random selection of subjects. These were student nurses who complained of sore throat, whose temperature was less than 100 and who had no indication for other types of therapy. Prior to treatment, a culture was obtained from the throat using swabs implanted on blood agar media.

The subjects were then listed as having received either medication "A" or medication "B" four times daily for two and a half days. Within two to six hours after taking the final medication, the subjects were again evaluated physically. Then, a second throat culture was taken. Before and after treatment, we examined the pharnyx, nasal mucosa, cervical region for adenopathy, oral temperature, and ascultation of the chest. Therapy such as analgesics, cough syrup, and nose drops was permitted, but if the patient subsequently required parenteral antibiotic therapy she was dropped from the study group.

In the final evaluation, in addition to the physical examination, a history was elicited as to whether there was a relief of symptoms completely, partly, or not at all. The examining physician was then requested to determine if, in his opinion, the response observed was due to medication. Of the subjects evaluated, 28 received group "A" troche and 30 the "B" troche. The study was conducted over a five-month period ending May 31, 1964.

Bacterial cultural studies before and after-treatment indicate that the subjects possessed a variety of organisms in their pharyngeal flora. We found fewer pathogens in the post-

TABLE I.[A] Bacteria in pre-treatment cultures:	TABLE I.[B] Bacteria in post-treatment cultures:
43 Gamma streptococcus	44 Gamma streptococcus
11 Hemolytic staphylococcus	6 Hemolytic staphylococcus
7 Beta hemolytic streptococcus	5 Nonhemolytic staphylococcus albus
4 Alpha hemolytic streptococcus	4 Beta hemolytic streptococcus
4 Hemolytic staphylococcus albus	6 Alpha hemolytic streptococcus
1 Nonhemolytic staphylococcus albus	3 Anerobic streptococcus
1 Anerobic streptococcus	3 Others.
3 Others.	

* From the St. Francis Hospital in Trenton, supported in part by a grant from the Squibb Institute for Medical Research.

TABLE II.

	Before treatment	After treatment
Cultures with single organisms	47	46
With multiple organisms	11	12

treatment cultures, but this did not bear any relationship to the type of medication used. Table II demonstrates a marked predominence of single organisms in the cultures.

TABLE III.

	Antibiotic troches	Placebo troches
Non-pathogen changed to pathogen	6	7
Non-pathogen on both cutures	11	12
Pathogen same on both cultures	1	2
Pathogen to different pathogen	2	3
Bacterial status not improved	20	24
Pathogen changed to nonpathogen	8	6

Table III suggests that those receiving the "A" troche (which contained the antibiotic) showed no evidence of improved bacterial status in 20 cases, but did have improved

TABLE IV.

	Antibiotic troches	Placebo troches
Had nasopharyngeal inflammation before therapy	28	30
Nasopharyngeal inflammation persisted after therapy	8	18
	36	48

bacterial status in 8 cases. The placebo group "B" showed no evidence of improved bacterial status in 24 cases with some improved bacterial status in 6 cases. Thus, *there is no statistical difference between the placebo and the active medication* in terms of the improvement of bacterial status before and after a two and one-half day period of therapy.

All of the antibiotic-receiving group had clinical evidence of nasopharyngeal inflammation before therapy. After the treatment, nasopharyngeal inflammation was found in only 28 per cent of the subjects. In contrast, those receiving the placebo had nasopharyngeal inflammation in 100 per cent of subjects before treatment and in 60 per cent following treatment.

This double blind, random selection, objective study does reveal a significant difference in the medicated and non-medicated groups in the rate of remission of nasopharyngeal inflammation.

These studies demonstrate no significant improvement in bacteriologic status using these antibiotics in these doses. However, we found objective improvement in the nasopharyngeal inflammation with the antibiotic troche. No conclusions can be drawn until more extensive studies are done. However, there is the possibility that neomycin sulfate and/or gramicidin exert an influence on some virus or viral-like agents which cause mild pharyngitis.

Summary

Fifty-eight student nurses participated in a study evaluating the antibiotic effectiveness of troches containing neomycin sulfate 2.5 milligrams and 0.25 milligrams of gramicidin. Placebo and medicated troches were administered in a double blind fashion to randomly-selected subjects. There was a decrease in pathogens in the post-treatment cultures, but this decrease bore no relationship to the test materials. There was no evidence of improved bacterial status in either group. This suggests that the antibiotic in this dosage had no significant effect. However, there was a significant difference in disappearance rate of nasopharyngeal inflammation. The group receiving antibiotic containing troches had 28 per cent residual nasopharyngeal inflammation. The placebo-receiving group had 60 per cent naso-pharyngeal inflammation following treatment. Further studies are needed to determine if the antibiotics have any effect on viral agents causing mild pharyngitis.

601 Hamilton Avenue (Dr. Fitzpatrick)

There's a lot we can do to prevent cancer, even in our present state of limited knowledge.

Is Cancer A Preventable Disease?*

Sylvan E. Moolten, M.D./New Brunswick

Theoretically all cancers would be curable if the diagnosis were made early enough and treatment applied immediately. Despite all the advances made in the last quarter of a century, reduction of cancer mortality, potentially possible, has hardly begun. The primary reason is the prolonged delay between the time when a patient has first symptoms and the time when definitive treatment begins.

Early detection of cancer is limited to sites accessible to study—such as the skin, the mouth, the female genital tract and breasts, the lungs, and the gastrointestinal tract. Alerting symptoms—such as hematuria, persistent cough, or abnormal uterine bleeding—are valuable in focusing attention on potential cancer sites.

The role of the physician in reducing cancer mortality is paramount. In his obligation to perform health maintenance examinations, each physician has the responsibility not only of encouraging regular examinations to detect early cancer but also of educating people in hygienic measures which are conceivably useful in preventing cancer.

What can be said of cancer prophylaxis? The industrial physician has specialized knowledge of environmental factors which are potentially cancerigenic. The suspected agents include petroleum products, nickel, aniline dyes, asbestos, and pesticide sprays. The physician ministering to the general public cannot sidestep the issue as it concerns the rest of the population. For example, no member of our profession can remain neutral any longer in the controversy about cigarette smoking. Because of the special prestige which the physician enjoys, he should not in good conscience smoke cigarettes and thereby discredit his own objectivity as an exponent of good health habits.

There is much more to cancer prevention than interdicting tobacco. For example, wisdom dictates removal of pigmented lesions from skin areas subject to chronic irritation; e.g., by a tight belt, tight shoes, or by tight shoulder straps and tight corsets in women. Avoidance of excessive exposure to sunlight will reduce the incidence of skin cancer, especially in blond persons. Removal of jagged projections from teeth and provision for well-fitting dentures may reduce the tendency to cancer of the tongue. Most authorities agree that circumcision in males protects against cancer of the penis and possibly may prevent cancer of the cervix in their sexual partners. Prevention of cancer of the stomach is theoretically tied in with prevention of chronic gastritis by avoidance of excessive use of spices, excessive intake of caffeine-containing beverages, or prolonged use of aspirin. The habit of drinking scalding soup or coffee may underlie the tendency of certain predisposed people to develop cancer of the esophagus or stomach. Correction of iron deficiency and vitamin A deficiency may aid in prevention of certain cancers of the mouth, esophagus, and female genital tract. Excessive intake of smoked meats and overheated fats has been blamed for the high incidence of cancer of the stomach in certain populations; for example, in Iceland.

Clearly the medical profession has a warranty

* Published on behalf of the Special Committee on Cancer Control of The Medical Society of New Jersey.

for an aggressive role in the campaign against cancer. Early detection and removal of precancerous lesions are truly part of cancer prophylaxis. The methods of exfoliative cytology have been abundantly vindicated in the campaign against cancer of the female genital tract. The same principle may be extended to early detection of cancer of the prostate, kidney and bladder, cancer of the breast (particularly Paget's disease of the nipple), cancer of the skin, and cancer of the lung.

A measure of sanity is needed if, in our energetic effort to eradicate cancer, we are to avoid another peril, the proliferation of cancerophobia. Every nevus need not be removed; nor should the pleasures of well prepared food be cast aside. The best reassurance is the knowledge that most individuals possess high natural resistance against cancer, even in the face of the host of environmental mutagenic agents capable to inducing cancer in our own and other species.

Middlesex General Hospital

The Rising Tide of Alcoholism

Alcoholics, particularly those with the most severe forms of the disease, are increasing among state mental hospital admissions, according to Dr. Stanley F. Yolles, Director of the National Institute of Mental Health.

A study by the U.S. Public Health Service reveals that one in seven newly admitted patients is an alcoholic, an 18 percent rise in 10 years. In 9 states, disorders associated with alcoholism lead all other diagnoses in mental hospital admissions. Recent figures show a startling rise in the number of alcoholics diagnosed with "chronic brain syndrome associated with alcoholism." Dr. Yolles calls this "the most hopeless of the three classifications of the disease." Patients in this group suffer irreversible destruction of brain tissues. The damage probably results from metabolic or nutritional defects caused by prolonged use of alcohol.

These alcoholics undergo severe personality changes, delirium, confusion, amnesia, confabulation, or talkativeness about things that never happened; also considerable peripheral neuritis. Often the encephalopathy is diagnosed by the electroencephalogram.

More than half the alcoholics now in state hospitals suffer from this irreversible form of alcoholism—a 50 percent increase in this group in the past 10 years. This rise occurred during a period when the number of patients in mental hospitals has dropped. Patients in public mental hospitals in 1952 totaled 531,981 in contrast to approximately 495,000 today. Resident patient rates for these hospitals have dropped from 438 per 100,000 population in 1952 to about 359.

In contrast to the "chronic brain syndrome" patients, the other two classifications of alcoholics, "acute brain syndrome associated with alcoholism," and "sociopathic personality disturbance, alcoholism addiction," have grown at a slower rate.

An analysis of one characteristic state (Ohio) furnishes this profile of the typical alcoholic admitted to a mental hospital: odds are better than 4 to 1 that he will be a male, probably separated or divorced, with little elementary education. He is most likely to be admitted to the hospital for the first time, in his forties.

The person least likely to become an alcoholic patient, according to these statistics, is a happily married female with some college education, either under 35 or over 54 years of age. Figures from other states show that the Ohio profile accurately represents the national picture.

This is, apparently, the first case on record in which a traumatic aneurysm was illustrated by superficial temporal arteriography.

Selective Superficial Temporal Arteriography*

Demonstrating A Post-Traumatic Aneurysm

Myron P. Nobler, M.D.
Sidney Ketyer, M.D.
John K. Donahue, M.D.
Elizabeth

Post-traumatic aneurysms of the superficial temporal artery are rarely reported. The lesion was originally described by Thomas Bartholin in 1740, in a case[1] in which instance a child was struck on the head with subsequent bruising, swelling, and aneurysm formation. The largest collection ever reported was amassed by Winslow and Edwards[12]. They reviewed the entire world medical literature through 1934 and analysed 108 cases. They found that only 79 of these were truly arterial. The other 29 were arteriovenous aneurysms. They added one case of their own to the list. In our more recent review of the literature, we were able to uncover only an additional 15 published cases (see bibliography). We could find only a single report featuring the arteriographic demonstration of a post-traumatic aneurysm of the superficial temporal artery, which was, interestingly enough, discovered as an incidental finding on a carotid angiogram which demonstrated a subdural hematoma.[13]

A 26-year old man was seen at St. Elizabeth's Hospital* for a scalp laceration over the left frontal bone. The cut was cleansed and skin sutures were applied without incident. The sutures were removed several days later, at which time the wound appeared to be healing well. Two weeks following the injury, the patient noted a "bump" in the region of the scar which was enlarging progressively, but which was not tender or painful. He sought medical attention several days later. One of us (J.K.D.) who had seen the patient previously, noted that this mass was pulsating, and made the diagnosis of a post-traumatic aneurysm (Figure 1).



FIGURE 1

Scalp and temporal region showing the aneurysm prior to the arteriogram. The aneurysm was purplish in color and palpably pulsating.

A superficial temporal arteriogram was then performed in the following manner: a small skin incision was made in the left preauricular region overlying the superficial temporal artery. The artery was easily isolated and a No. 23 needle was inserted directly into it. Three cubic centimeters of 50 per cent Hypaque® were slowly injected and serial films were obtained during injection. These revealed a bilobulate aneurysm of the superficial temporal artery, lcm in diameter, which was not in direct communication with the venous system (Figure 2).

The patient was then taken to the operating room where the area was explored. The aneurysm was found to be adherent to the skin and subcutaneous tissues. The superficial temporal artery was ligated proximally and distally, and the aneurysm was excised *in toto*. The patient did well post-operatively, and the wound healed without incident. The pathologic report was: "Aneurysm of artery with adherent mural thrombus. The findings are consistent with those of a traumatic aneurysm."

* From the Departments of Radiology and Surgery, St. Elizabeth Hospital, Elizabeth, New Jersey.



FIGURE 2

Left superficial temporal arteriogram, arterial phase, lateral projection. The opacified aneurysm is in direct continuity with the superficial temporal artery. Note the opacification of the superficial temporal artery distal to the aneurysm. There is no evidence of a direct venous communication.

All forms of trauma have been implicated as etiologic factors. It is interesting, therefore, to consider the changes in etiology which have taken place through the years. The majority of cases reported by Winslow and Edwards,[12] which are our earliest citations, had actually occurred during the early part of the nineteenth century, at which time temporal arteriotomy was a popular treatment of apoplexy and epilepsy. In those days, duelling was considered a sensible method of settling disputes. Understandably, then, these were the two most common causes in their series.

Contrary to what one might expect, the role played by injury sustained through modern methods of warfare is apparently rather minimal. Jahnke, Hughes, and Campbell[7] treated 182 traumatic aneurysms which were acquired during the Korean War. Only three of these involved the superficial temporal artery; but since two of these were arteriovenous fistulas, only one was a purely arterial aneurysm.

More recently, traumatic aneurysms caused by injuries sustained during active participation in sporting events have been reported with increasing frequency. One was cited by Gittes and Kartchner[6] as due to a direct blow with a hockey stick; one of Davies'[3] cases was caused by a direct blow with a baseball; and both of those reported by Campbell, Fournier and Hill[2] came from injuries sustained by a direct blow from a flying puck, the active instrument in ice hockey. (The latter authors coined the catchy phrase "puck aneurysm," which aptly describes and defines these lesions.)

In view of the vulnerable position of this artery, and the extensive range of violent forces to which the head may be exposed these days, it is surprising that this lesion is not observed more frequently. Does it go completely unrecognized, or is it mis-diagnosed? Is it mis-identified as a sebaceous cyst or other simple lesion? If so, is this because of a poor history (ie. trauma forgotten) or because pulsations are not palpated (which may very well occur if the aneurysmal sac is completely occluded by thrombus)?

History and Physical Findings

In all cases there is a history of trauma, either from the causes noted above or due to a fall or direct blow. The wound may be open or closed: 33 of Winslow and Edward's 79 cases[12] were associated with closed injury; 46 followed an open wound. At various times (weeks to months) following subsidence of the signs of original trauma, patients begin to note a small lump in the area of trauma. Most of these aneurysms are small (less than an inch in diameter). Pulsation, which is noted in some cases, is undoubtedly related to the presence or absence of thrombus in the lumen of the aneurysm. If pulsation is present, it can be ablated by pressure on the proximal portion of the superficial temporal artery.

Pathology

Traumatic aneurysms or pseudoaneurysms arise when rupture of a vessel wall (usually an artery), is incomplete, thus permitting the adventitia to contain the subsequent hemorrhage. If there is complete rupture of the vessel wall, pseudoaneurysms will develop in areas where the vessel is so firmly supported

by surrounding dense connective tissue that bleeding remains localized. In either case, the collections of extra-luminal blood maintain a direct connection with the arterial circulation. Varying degrees of thrombus formation are noted within these aneurysms. A larger thrombus will obliterate pulsations when it occludes the central lumen of an aneurysm, whereas pulsations will be palpable if little or no thrombus is present.

Summary

A case of post-traumatic aneurysm of the superficial temporal artery is reported. So far as we know, this is the first case to be illustrated by selective superficial temporal arteriography. We have reviewed the existing literature briefly, and the etiology, history, physical findings and pathology of lesions of this type are further discussed.

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204 South Broad Street

ONE PICTURE = A THOUSAND WORDS

We're not sure that Confucius really said that one picture was worth 1000 words. But no matter who said it, it's true. And at the Annual Meeting this year, you will find an exciting gallery of such "pictures": our exhibits . . . Scientific, Informational, and Technical. See for yourself!

Social planning should involve the physician, too. Doubly so when the planning is aimed at a comprehensive medical—here a psychiatric—service.

Planning For Mental Health Services*

The Physician's Role

Evelyn Parker Ivey, M.D./Trenton

With mental health planning gaining momentum, it is essential for physicians to become involved. Such involvement is vital both to the community and to the physician. Along with other states, New Jersey has embarked on a bold approach to combat mental illness. Within the framework of the *Guidelines* from the National Institute of Mental Health, each state tailored its own individualized "Plan for Planning" to qualify for a federal appropriation. In contrast to other states, New Jersey's basic unit for planning for comprehensive mental health services is the County Mental Health Planning Committee. County emphasis is consistent with New Jersey's political philosophy of strong county government. At the state level, sixteen task forces study special problems. The State Mental Health Planning Study Group reviews the work of all committees and makes decisions. The state plan will be written with full consideration of the recommendations of the Task Forces and the 21 county proposals for comprehensive mental health services. The Office of Planning in the Division of Mental Health and Hospitals of New Jersey's Department of Institutions and Agencies† carries the responsibility for this planning operation.

The County Mental Health Planning Committee includes broad representation of all health, education, and welfare services; government, citizens groups, and geographic areas of the county. The leadership of physicians especially in county and state planning committees is indispensable. It seems appropriate, therefore, to examine the role of the physician under three categories:

A. That of the physician who has specialized in psychiatry.

B. That of other physicians, including the general practitioner, family physician, and other specialists.

C. The unique role required of the physician in mental health planning.

A. The psychiatrist has special knowledge and experience which aptly qualifies him:

1. To assist in the evaluation of existing services and the way in which these meet the needs of the people.

2. To evaluate the dynamics of the community.

3. His is the key role of insuring that services meet professional standards and the needs of the individual patient.

4. The planning organization provides the framework within which the psychiatrist can assist in the coordination of all services: prevention, case-finding, diagnosis, treatment, and rehabilitation.

5. The planning organization provides the framework within which he can obtain the information which will enable him to reevaluate his own practices, his allotment of professional and personal time, his ethics, and to determine ways in which he might alter his practices to serve his patients more effectively and give leadership to the community.

6. Further, the planning organization provides the framework within which he can establish improved communication and relationship with his colleagues working in other settings: private practice, clinics, hospitals, schools, and industry. In such a forum he can learn from and contribute to his fellow physicians, so that all become a part of the team in understanding and dealing with the emotional aspects of illness.

The advantage of this is not limited to the patient but is of inestimable value to the psychiatrist. The psychiatrist improves his skills in response to the requirements of his

* Based on Dr. Ivey's discussion of Dr. Kaufman's talk on the "The Stake of the Practitioner in Mental Health Planning," September 17, 1964 at the N.J. Congress on Mental Health held in Princeton.

† Dr. Ivey, author of this article, is Director of Planning for New Jersey in this program.

patients. Medical progress is dependent to some extent, therefore, upon the physician's carrying the responsibility for continuity of care of his patients or upon his learning what happens to his patients when he no longer sees them. This is true for all physicians. But prior to the movement of psychiatry into general hospitals, the psychiatrist had no natural communication channel through which he might hear of his former patients. At present, continuity of care is fostered only when the psychiatrist sends his patient to a private hospital which returns the patient at the time of discharge with a report to the referring doctor. We psychiatrists need to know what happens to our patients. The communication within the County Mental Health Planning Committee between representatives of clinics, hospitals, agencies, and correctional services can facilitate an exchange of information and promote ways of enabling the physician to participate in the care of his patient through the various phases of diagnosis, treatment, and rehabilitation. Only with such knowledge can we evaluate ourselves and our care of patients and continue to upgrade our own abilities.

B. Let us next consider the role of the other physicians; i.e., general practitioners, family doctors, and other specialists. New Jersey, along with the American Medical Association, has been moving toward and benefiting through the re-integration of psychiatry and medicine. All physicians recognize the impact of emotional problems in all illness. We need to examine the ways in which this knowledge influences the treatment of the total individual:

1. Physicians have a wealth of experience from which facts can be extracted and shared with colleagues. This would materially help in planning.

2. The physician can use his knowledge of patients' needs and the availability and limits of resources to define the problems, to determine gaps in services, and to establish priorities.

3. He can help clarify when and how a patient should be referred to a psychiatrist for consultation and possibly for continued treatment; and the ways in which he also can participate.

4. He can contribute to ours and his better understanding of when the physician might seek psychiatric consultation to enable him more ably to use his personality for the continued improvement of his patient.

5. It has been said that the physician offers the first line of defense in mental illness. His relationship with his patients in health and illness affords him the opportunity to star in the prevention of mental illness. His experience and knowledge about prevention, early recognition, diagnosis, treatment, and related problems are of crucial importance to the planning committees. With the committee he can examine ways in which all the community resources can be more effectively coordinated to promote mental health.

6. As in the case of the psychiatrist, the County Mental Health Planning Committee provides the framework within which he can obtain information essential to his own reevaluation of his practices, including the use of his professional and personal time, and his own goals and effectiveness in helping his patients.

7. His leadership in the Medical Society will enable him to collect information from its members which he can convey to the Planning Committee. He equally has the responsibility to inform the Medical Society of developments in planning.

C. The physician involved in planning for comprehensive mental health services must adapt to the new requirements. The necessity to balance the increasing needs for services with the shortage of manpower will stimulate his creative thinking. He will consider his relationship to mental health resources which are not under medical responsibility and which heretofore may not have come under his purview: family, counseling, educational, guidance, welfare, and correctional services are examples.

Instead of his familiar role as the authority or the unchallenged expert when speaking to a community group, the physician in the planning operation must adopt the role of a consultant. In meeting with the broadly representative Planning Committee, then, humbly, he will assist in determining the facts and in reevaluating them in the light of all developments. Yet his medical authority appropriately applied remains unchallenged. The physician has the responsibility to see that sound investigative measures are used, that services are planned to meet the needs of the individual, that good decision-making processes and good medical principles are applied in planning.

In comprehensive mental health planning, the physician has a framework within which to exert an unprecedented type of leadership. He has the opportunity to work as one of a group of citizens on a challenge that includes numerous aspects and requires the talents and creative thinking of many different disciplines.

Let us physicians meet this challenge skillfully, with grace and modesty.

167 West Hanover Street

A safe and moderately effective blood-pressure reducer seems to be the verdict in this careful study of chlorthalidone.

The Antihypertensive Action of Chlorthalidone*

Duncan E. Hutcheon, M.D., Ph. D.
Genevieve B. Leonard, R.N.
Mortimer L. Schwartz, M.D.
Jersey City

In 1960, Mach[1] introduced chlorthalidone as a diuretic and antihypertensive agent. Since then, it has become one of the mainstays in the treatment of essential hypertension and hypertensive cardiovascular disease. The decrease in blood pressure produced by the chlorthalidone and related diuretics was originally assumed to be due to their natriuretic effects. Recent experiments, however, have demonstrated that the diuretic and antihypertensive properties of this group of drugs may be independent of one another.[2,3]

In the present study, the relative effects of chlorthalidone on systolic and diastolic blood pressure of hypertensive patients are described. The relation between the effect of the drug on arterial blood pressure and urinary sodium and potassium excretion is recorded in patients on electrolyte-balance studies. Results indicate that the fall in blood pressure caused by chlorthalidone is not always accompanied by a simultaneous natriuretic response.

Methods

Observations were made in 11 hypertensive patients attending the cardiac clinic of the Jersey City Medical Center and in 5 patients admitted to the Seton Hall Clinical Research Center for electrolyte-balance studies during chlorthalidone therapy.

Out-Patient Studies. Patients with essential hypertension and hypertensive cardiovascular disease were seen in the clinic at weekly intervals. Patients were interviewed and examined at each visit. Averages of four systolic and four diastolic readings were recorded with the patients in both the sitting and standing positions. We prescribed medication in the following sequence: (1) placebo for 2 weeks; (2) chlorthalidone at one dose level for one week; (3) placebo for 2 weeks; and (4) chlorthalidone at a second dose level for a final week. Chlorthalidone, in a dose of 50 or 100 milligrams, was substituted for the placebo, using capsules of the same appearance. Order of the dosage was assigned at random. Chlorthalidone and placebo were administered in capsules of the same appearance in a double-blind design so that patients and observers were unaware of the medication being administered. The significance of the blood pressure changes produced by chlorthalidone was measured by means of the Student t-test.[4]

In-Patient Studies. Patients admitted to the Metabolic Ward of the Seton Hall Clinical Research Center were placed on a constant diet containing 43 milli-equivalents of sodium and 47 of potassium per day. Fluid intake was maintained at a constant level; urine was collected at 12-hour intervals. Urine sodium and potassium concentrations were measured

* From the Departments of Pharmacology and Medicine, Seton Hall College of Medicine and Dentistry, Jersey City, N.J. The Geigy brand of chlorthalidone used in this study is tradenamed Hygroton.® This project was supported by Grants HE-0540 and OG-17 from the United States Public Health Service.

by internal standard flame photometry. Plasma sodium and potassium concentratitons were determined daily. The cumulative sodium balance over four days of therapy was measured and related to changes in arterial blood pressure which occurred during this period.

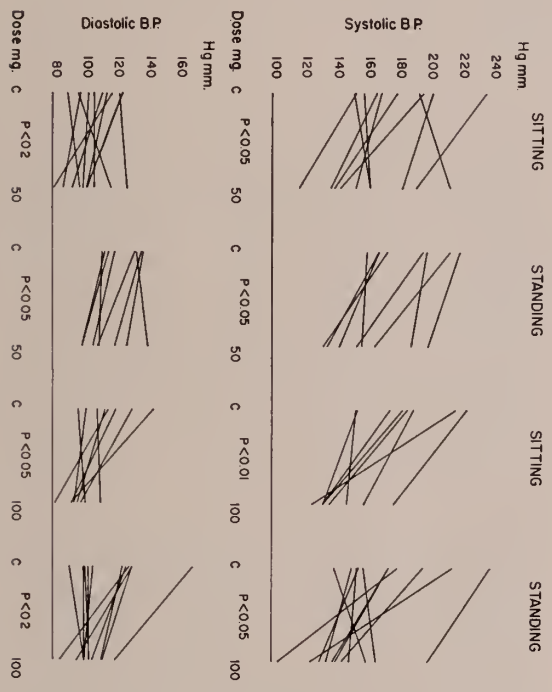


FIGURE 1

Changes in systolic and diastolic blood pressure of patients with essential hypertension and hypertensive cardiovascular disease, receiving chlorthalidone, in doses of 50 and 100 mg. per day for one week. C, control blood pressure after 2 weeks of placebo therapy.

Results

Chlorthalidone, in doses of 50 and 100 milligrams per day for one week, caused a significant decrease in systolic and diastolic blood pressure in eleven patients with essential hypertension and hypertensive cardiovascular disease (Figure 1). The greatest antihypertensive response (—44/—21 millimeters) was observed after the 100 milligram dose in patients in the sitting position. Average blood pressure changes in the standing position after the 100 milligram dose were —30/—14 millimeters. No evidence of postural hypotension was obtained from immediate blood pressure readings in patients assuming the standing position.

In-Patient Studies. Changes in blood pressure and renal electrolyte excretion produced by chlorthalidone in a patient with hypertensive cardiovascular disease (Case 1) are shown in Figure 2. Chlorthalidone (100 milligrams per day for 7 days) caused an increase in renal sodium excretion which was greatest in the 12 to 24 hour period after the first dose of the drug. Sodium excretion was increased to a greater extent than potassium excretion and plasma sodium and potassium concentrations remained within normal limits during the period of therapy. Systolic blood pressure fell during the first two days of drug administration; but diastolic pressure did not decrease below control levels until the fifth day of drug administration after sodium balance had been re-established.

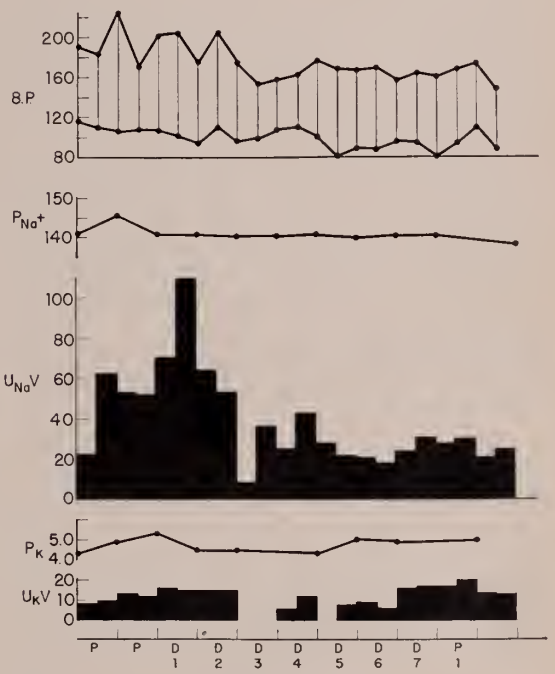


FIGURE 2

Effects of chlorthalidone, 100 mg. for one week, on renal electrolyte excretion and blood pressure, on a 68 year old male with hypertensive cardiovascular disease and congestive heart failure.

Blood pressure levels and cumulative sodium balance after 4 days of chlorthalidone therapy in hypertensive patients are shown in Table

Table 1
SUPINE BLOOD PRESSURE AND ELECTROLYTE CHANGES DURING FOUR DAYS OF TREATMENT WITH CHLORTHALIDONE (100 MG PER DAY ORALLY).

Patient	Cumulative Sodium Balance mEq	Cumulative Postassium Balance mEq	Blood Pressure Control mm Hg	Blood Pressure Treated mm Hg	Plasma Sodium Control mEq/l	Plasma Sodium Treated mEq/l	Plasma Potassium Control mEq/l	Plasma Potassium Treated mEq/l
1	−218	+ 79	200/106	176/100	142	142	4.9	4.3
2	−218	−130	175/125	155/121	147	144	4.7	3.4
3	−214	−137	157/110	130/94	148	149	4.5	3.9
4	− 15	+ 37	180/108	156/96	146	139	4.4	4.0
5	−420	−278	189/96	149/93	141	135	4.5	3.2
Mean	−217*	− 85.8	180/109	153*/101*	145	142	4.6	3.76*

*$P < 0.05$

1. Although systolic blood pressure was reduced by an average of 27 millimeters, diastolic pressure decreased only 8 millimeters in spite of the fact that in 4 of the 5 patients studied the drug caused a natriuretic response with a cumulative balance between −214 and −420 milliequivalents of sodium. In one patient (Case 4) treated with 100 milligrams chlorthalidone daily for 4 days, renal sodium excretion did not change appreciably but the patient had a 24 millimeter fall in systolic pressure and drop of 12 in the diastolic pressure during this period.

No significant changes in plasma sodium concentrations were observed during the period of chlorthalidone therapy, but plasma potassium concentrations decreased slightly in all patients. The average change in potassium concentrations (−0.8 mEq/liter) was statistically significant (p was less than 0.05).

Discussion

Chlorthalidone is a monosulfamyl-phthalimidine derivative with diuretic and antihypertensive properties. In normal subjects, chlorthalidone has been demonstrated to have a longer duration of action than chlorothiazide.[1] Sodium and chloride diuresis continues for 48 to 72 hours after single dose of 100 and 200 milligrams in patients with edema.[5] In patients without evidence of fluid retention, renal Na:K excretion ratio has been reported to be 2 to 1 after chlorthalidone administration. Chlorthalidone-induced diuresis has been observed in hepatic cirrhosis,[5] edema of pregnancy,[6] and congestive heart failure.[7] Bryant *et al.*,[8] reported that chlorthalidone administered in a single oral dose of 200 milligrams per day produced a significantly greater hypotensive response than chlorothiazide in a dose of 250 milligrams, three times daily. Because of the long duration of action of chlorthalidone, satisfactory antihypertensive effects have been achieved in ambulatory patients receiving 100 to 200 milligram doses of the drug three times weekly.[9]

It has generally been assumed that the antihypertensive effect of chlorthalidone is related to its saliuretic action. Certainly, a negative sodium balance may facilitate a drop in blood pressure in patients receiving chlorthalidone. However, it does not necessarily follow that sodium depletion produced by the drug is responsible for its antihypertensive action. In the present study, the reduction in blood pressure produced by chlorthalidone did not always parallel its effect on sodium excretion. The results, therefore, suggest that chlorthalidone has an extra-renal site of action which is responsible for its antihypertensive effect. Presumably, chlorthalidone has the same direct inhibitory effect on vascular reactivity as chlorothiazide and its more immediate chemical derivatives.[10]

Summary

1. Chlorthalidone in daily doses of 50 and 100 milligrams for one week caused a significant reduction in systolic and diastolic blood pressure in patients with essential hypertension and hypertensive cardiovascular disease.

Blood pressure reduction was not significantly greater when the patients were in the standing, compared with the sitting, position.

2. Although the fall in blood pressure produced by chlorthalidone may be facilitated by salt depletion, electrolyte-balance studies revealed that the natriuretic effect of the drug did not always coincide with its antihypertensive action.

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24 Baldwin Avenue

Your Traveling Patient

Every day hundreds of travelers run into delays in quarantine. The reason: They fail to present a valid international certificate of vaccination. The form is given out with the passport application. It may also be obtained from local and state health departments or from the U.S. Public Health Service. In addition, it may be bought from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, at ten cents a copy.

To be valid, the certificate must be completed as follows:

Name of the person vaccinated or revaccinated

His signature (a parent may write in a child's signature)

Date of birth

Date of vaccination or revaccination

Record of primary vaccination, read as successful, or a revaccination

Written signature of the vaccinating physician, even through his nurse or technician may have given the vaccination under his supervision.

A stamp approved by the health department of the area in which the physician practices.

The validity of a certificate extends for 3 years, beginning 8 days after the date of a successful primary vaccination or on the date of revaccination.

Additional information on required and recommended immunizations and on health precautions for international travel is available in leaflets issued by the Division of Foreign Quarantine for travel in Asia, in Europe, in Africa, and in Latin America; in a leaflet entitled "So You're Going Abroad;" and in a booklet entitled "Immunization Information for International Travel." Copies may be bought from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. The leaflets sell for five cents apiece or $3.75 per hundred, and the booklet sells for 35 cents. Single free copies of the leaflets are available from the Public Health Service at 7915 Eastern Avenue, Silver Spring, Maryland 20910, if you write for them on your letterhead or Rx blank.

Xanthomatosis sounds trival; but in cases like this, can be fatal.

Atherosclerosis and Aortic Stenosis in Hypercholestermic Xanthomatosis

Thomas M. Kain, Jr., M.D./Camden

In 1954 when the case of Barr, Rothbard and Eder[1] was reported, a similar case was under our care. This patient is presented because of the similarity to Barr's case and also, it clearly illustrates the marked degenerative vascular changes that occur in familial xanthomatosis. Involvement of the cardiovascular system in xanthomatosis was observed as early[2] as 1873. In the last ten years considerable research and discussion have been carried out concerning degenerative vascular disease and its relationship to neutral fats, cholesterol phospholipids, and so on. The x-ray findings in this case have been reported elsewhere.[3]

A 34 year old man was admitted to Cooper Hospital in Camden with generalized joint pains, headache, chills, and fever. This began seven days earlier. He had to go to bed for three of those days. He seemed to improve and returned to work only to develop abdominal pains and cough, with swelling and redness of the knees, ankles, and feet. He was admitted to the hospital on a stretcher.

He had had scarlet fever and rheumatic fever between the ages of 14 and 16. At age 22, he had a recurrence of joint pain with swelling and redness of the knees and ankles. At the age 5, his parents noticed large nodules on the buttocks, knees, wrists, and feet. On two occasions, nodules were removed from his lower extremities with recurrence. At times he stated the nodules became red and tender. In 1942 he suffered a "heart attack," preceded by chest pain with effort for two years. He required bed rest and was treated with a low fat diet and restriction of heavy activities. He had been taking tablets of nitroglycerin off and on for chest pain since 1942.

His father also had nodules on his fingers. A maternal aunt had nodules on her extremities and suffered angina pectoris. She died at the age of 48 from heart disease. One sister has nodules on her hands.

The patient has three children, none of whom have evidence of xanthoma.

On admission his temperature was 104. Blood pressure was 120/70 and pulse was 90. He had xanthomata of the lids and severe dental caries. Lungs showed diffuse rales bilaterally. Heart was normal in size, with regular sinus rhythm. There was a Grade 2 systolic murmur at the aortic area with an absent A2 and a Grade 2 systemic mumur at the apex with a third sound. No diastolic murmurs were heard. The liver was palpable two fingers below the costal cage. There were nodules of varying sizes and shapes (see figure) involving his elbows, buttocks, knees, ankles, extensor surfaces of the phalanges and on the Achilles tendons. These tumors were soft, yellow in color and fairly movable. Some were pedunculated. There were no signs of peripheral hemorrhages. Rectal examination was negative. He had a right hydrocele.



XANTHOMA OF FINGERS

Hemoglobin was 75 per cent, with 3,700,000 red cells, 9,400 white cells and a normal differential. Platelet count was normal. Sedimentation rate was 30 millimeters in one hour. Blood urea nitrogen and sugar were normal. Total protein was 7, with a 1 to 1 A/G ratio. Serum cholesterol was 488 milligrams per cent, with esterification of 348 milligrams per cent. Serum uric acid was normal. Urinalysis was negative. Antistreptolysin O titer normal. Glucose tolerance test normal. Subsequent blood counts showed no change. The first blood culture was reported staphylococcus aureus. Three subsequent blood cultures were negative. Electrocardiogram revealed signs of a posterolateral wall infarction. Chest x-ray reported accentuated markings at the right base, extending to the costophrenic sulcus, with a suggestion of a pneumonic process in the right lower lung field. The heart was reported as normal in size and contour. There was no displacement of the barium filled esophagus. The x-ray examination of the left wrist and hand revealed a punched out subarticular bony defects in the base of the proximal phalanx of the index finger adjacent to large soft tissue opacities. Detailed x-ray studies associated with this disease have been previously reported.[3]

Following the positive blood culture for staphylococcus aureus, penicillin therapy was instituted. The patient's temperature promptly returned to normal and remained so throughout his stay. Two days after admission, splinter hermorrhages were seen under the finger nails. A diagnosis of bacterial endocarditis was made, confirmed by the blood culture. Throughout his stay his heart rate remained normal. There were no significant changes in his murmurs and no diastolic murmur ever developed.

In an attempt to lower the serum cholesterol the plant sterol beta sitosterol[4] was administered. The sitosterols are plant sterols or phystosterols. The most extensively studied sitosterols are beta and gamma and differ only in the spatial configuration of the C-17 side chain. Beta sitosterol is the main sterol of cottonseed oil, tall oil, and wheat germ oil. Gamma sitosterol is the principal sterol of soy bean oil. There was no improvement in this patient's serum cholesterol with sitosterol therapy. At the time of discharge, his serum cholesterol was 578 milligrams per cent. The lesions from the left buttocks and right elbow were removed without complications. During his hospitalization an attempt was made to perform a bromsulfalein, but he developed a severe anaphylactic reaction with hypotension, syncope, and, for the first time, chest pain. Electrocardiogram at that time showed no significant change. It was felt he suffered an attack of acute coronary artery insufficiency, and from that time until discharge he required nitroglycerin for the relief of pain.

After three weeks of penicillin therapy, aqueous heparin (50 milligrams) was given in an attempt to aid the serum cholesterol.[5] There was no significant effect. When discharged, he was up and about, requiring nitroglycerin periodically for pain. He was continued on beta sitosterol and given a low fat diet.

One month after discharge, he suddenly expired.

Post-mortem* revealed numerous rather large, soft, sessile, and pedunculated tumors, projecting from the extensor surfaces of his extremities including the phalanges, elbows, buttocks, knees, ankles and Achilles tendons. Most of these tumors were soft, fleshy, orange yellow, and fairly movable. Those on the tendons were deeper and more fixed. The largest one projected from the left buttocks and measured 10 by 8 by 6 centimeters.

Internal examination showed no excess fluid in any of the serous lined cavities. The heart was enlarged transversely, and weighed 500 Grams. There were several grey white soft plaques on the ventral surface in the midline. The myocardium was firm and dark red. The left ventricle was firm, measuring 25 millimeters and the right 9 millimeters. The leaflets of the aortic valves were greatly thickened and calcified. There was stenosis of the aortic ring. Numerous, irregular, orange, hard plaques were projecting from the valve and from the ventricular surface, just beneath the valve. Some projected out a distance of 8 millimeters, like small polyps. The capacity of the valve was diminished by the thickening. The ostia of both coronary vessels were diminished about one-half, due to thickened plaques projecting into the lumen. This was more marked on the left than on the right. A false opening was noted 10 millimeters above the aortic valve on the ascending aorta half way between the right and left coronary ostia. This ostia measured 4 millimeters in diameter. A small firm clot projected through the lumen. This opening communicated with a smooth lined structure behind the ascending aorta and adjacent to the auricular appendage, the slit measuring 15 millimeters in diameter. The clot appeared well organized and was adherent to the wall. The rest of the aorta showed multiple large grey, irregular, firm, yellow plaques continuing throughout the entire aorta. The severity became increased as the iliac vessels were approached. The diameter of the vessels of the arch of the aorta, as well as the iliac and renal artery, were narrowed considerably due to moderate arteriosclerosis. Some of these plaques were calcified, particularly in the iliac region and showed ulceration and thickening. The aorta resembled that of a very elderly individual. The other valves of the heart were not remarkable. The endocardium was smooth and glistening. No vegetations were noted on any valve, including the aortic. The endocardium was firm and cut with increased resistance. This was particularly true in the ventral surface of the left ventricle. The myocardium was pale as compared with the outer two-thirds which was firm and red.

The liver was large and projected two fingers below the right costal margin and weighed 2000 grams. The spleen, enlarged to twice its normal size, showed numerous hemorrhages. The kidneys were one-half normal size. Ureters, bladder, and genital tract appeared normal.

Xanthomatosis is a hereditary disorder of lipid metabolism as seen in this patient, characterized by plaques and nodules over the elbows, knees, buttocks, tendons, and joints of the fingers, toes, wrists, and ankles.[2] He also showed xanthelasma of the eye lids, characteristic of this disease. This disease is of great cardiac interest because of the frequency of angina pectoris with coronary atherosclerosis and sudden death, also exhibited by this patient.[6] Idiopathic hyperlipemia differs in that neutral fat is primarily and considerably elevated along with cholesterol and phospholipids.[7] The heparin, as

*Performed by Robert L. Breckenridge, M.D., pathologist at Our Lady of Lourdes Hospital.

tried in this patient, had no significant effect in hypercholesterolemia due to the fact that neutral fats, as a rule, are normal. Heparin will alter the viscosity and the turbidity of the blood because of its dispersing property.[5] Heparin will produce no consistent effect upon the cholesterol phospholipid, free cholesterol phospholipid, or cholesterol esters cholesterol ratios.

Xanthomata of the tendon is not as frequent in idiopathic hyperlipemia, and the incidence of coronary heart disease also is less frequent in this condition. Idiopathic hyperlipemia as a rule consistently shows milkiness of the plasma. From an electrophoretic analysis, there is always an elevation of the alpha-2 peak, which is never elevated in primary xanthomatosis, associated with hypercholesterolemia.[7] The best evidence to date suggests that familial hypercholesterolemia is transmitted as an incomplete dominant trait.[2]

Summary

This is a case of familial hypercholesterolemic xanthomatosis in a man who died at the age of 34 from the complications of severe atherosclerosis. Included also is the pathological report. The patient exhibited calcific aortic stenosis with rupture of a plaque forming an aneurysm above the aortic valve and extensive generalized vascular atherosclerosis. Treatment with beta sitosterol and heparin showed no effect on the patient's serum cholesterol. A discussion of genetics and comparison between hyperlipemia and familial xanthomatosis is made.

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403 Cooper Street

GENERAL SESSION

Sunday, May 16, 1965, 3:00 p.m.

THE FUTURE OF ORGANIZED MEDICINE

James Z. Appel, M.D., President-Elect

American Medical Association

Members of The Medical Society of New Jersey and of the Woman's Auxiliary and their guests are cordially invited to attend this session.

Here is one medical teacher's point of view on the controversial question of medical education in our state.

The Future of New Jersey Medical Schools

Philip H. Henneman, M.D./Jersey City

The recent article by Dr. Fred A. Mettler in this JOURNAL (61:458) and the published conclusions of the Governor's Committee, including the letters of Dean Stetten regarding medicine in New Jersey, constitute public discussion in an area previously limited for lack of public forum. They are welcomed by everyone interested in New Jersey medicine. I would like to add the views of some of the medical faculty which already has produced doctors in this state, particularly in regard to Dean Stetten's emphasis on laboratory versus bedside medical education and to questions raised by Dr. Mettler as to whether the sole purpose of a medical school was to produce physicians; whether a medical school should use community hospitals for teaching; and whether a major medical center is needed in New Jersey.

The Purpose of a Medical School

Few would define the purpose of a medical school as the production of physicians to the *exclusion* of other scholarly functions. These other functions include a major part of the medical research which constitutes one of the great gifts of the United States to all peoples of the world. Medical faculties serve as editors and reviewers of medical journals, as panel members, study section members and advisors to the National Institutes of Health and all other national medical bodies. Medical school faculties provide independent review of the claims and products of our great pharmaceutical industry and thus contribute to the health and safety of the population at large. Indeed, a school which solely trained physician-candidates would represent a reversion to an earlier, less advanced period in medical education. Such a school would experience difficulty recruiting a faculty for this incomplete task and would fail to indicate to its students the many ways they may serve as physicians.

The Community Hospital and the University Hospital

A complete four year medical school and its teaching hospital constitute a unity. Medical students learn best from those only slightly more advanced chronologically than they. The fourth year student provides the pattern for the third year student while he himself emulates the intern. On this chain of living education shine the brilliant lights of the basic sciences whose methods and research explain the medicine of today and which become the medicine of the years ahead. The house staff and students learn best by assuming responsibility for the care of large numbers of patients with widely varied illnesses. An average medical school class of 100 students requires a hospital of approximately 1,000 beds to ensure the quantity and variety of medical experience necessary for training. Private patients can contribute to a teaching program but reduce by very little the basic requirement of 1,000 ward beds. Thus the best medium for education as a physician is the large university-type hospital which serves also as city hospital in an urban area. Such institutions arise in response to the need of

the population, not at the convenience of a faculty. The first two pre-clinical years can be taught anywhere; however, there is an increasing tendency to integrate such training with the clinical experience. The first and second year students absorb from the juniors and seniors the standards of hard work and devotion to the needs of the patient which characterize the best of our profession.

Community hospitals are small by definition, necessarily limited in their resources, and primarily devoted to private patient care. Community hospitals may supplement but cannot substitute for a university hospital teaching program. Community hospitals are essential elements in the fabric of medical care, and in the future there will be an increasing liaison between university and community hospitals. Many members of our faculty wish to increase their already active contribution to the community hospitals of New Jersey and feel that there can and must be an even more useful exchange between the medical school and community hospitals in the future. More specifically, the medical school can help with the on-going education of the practitioner and with resident staffing; moreover, the community hospital can play an important role in combined group study of disease and therapeutics. This relationship deserves careful study, nurturing, and development by both parties—not to the exclusion of either one but rather for their mutual assistance in the profession of medicine.

A Major Medical Center in New Jersey

Another relatively new medical school, the Albert Einstein College of Medicine, was not deterred by the existence of several great medical schools and medical centers in New York City but has gone far in less than ten years toward the goal of another major medical center in that city. New Jersey not only has the wealth but the responsibility to produce one or more major medical centers. A major medical center can no longer be regarded as a luxury but rather, in this age of social consciousness, a civic responsibility. The great medical centers produce physicians, educators, and scientists; attract superior faculties and offer the most help to the physician in practice. Major medical centers represent a tremendous financial investment; however, it should be pointed out that such centers can provide clinical training for the students of two or even three two-year medical schools. Most New Jersey physicians do not wish to lose patients to medical centers in other states and chafe under the opprobrium of practicing in a "second class" medical milieu. Most patients would prefer medical care closer to home and without the problems of extending insurance coverage to another state. One should add that such centers include modern, accurate, reliable clinical laboratories—model facilities woefully lacking to date in most areas of New Jersey.

Bedside Medicine

There is general agreement among medical educators and practitioners that we learn best from the individual patient. Bedside teaching is here to stay! However, scientific knowledge is doubling every ten years; to prepare young doctors for their 40-year careers we must provide them with as sound a scientific background as is possible within certain natural limits of time, funds, and aptitudes. The medicine of 1975 will be based in large part on the "basic science" training of 1965. Never before has the interrelation of medical sciences and medical practice been so close; the trend is clearly toward more science and less guesswork in medical practice. There is no longer a choice between "clinical" and "scientific" training; these disciplines, and the faculties which serve them, are now integrated, interrelated, and indissoluble.

Whence Seton Hall College of Medicine?

As one who has worked for six years to help produce New Jersey's first medical school, I wish to call attention to one more possible solution in addition to those openly discussed to date. Whereas all agree that the present hospital-medical school arrangement in Jersey City is unsatisfactory, it should be noted that it might be less expensive for the State to purchase and remodel the entire Jersey City Medical Center complex than to build a much less adequate and smaller university-type hos-

pital elsewhere. The Jersey City Medical Center is a heavy financial burden to Jersey City and Hudson County and might be offered to the State at much less than replacement value. It should also be pointed out that Newark and Jersey City-Hudson County are the only municipal entities in New Jersey large enough to support 1,000 bed teaching hospitals and that the Jersey City Medical Center is the only present collection of buildings in New Jersey with the potentiality for remodeling to fill the needs of a major medical center. State purchase of the Jersey City Medical Center would avoid disruption of the already successful programs and laboratories of the department of medicine which have attracted research support totalling approximately one million dollars annually, would encourage continuing United States Public Health Service support and development of these hospitals, and would provide stability to the School during this crucial period. Any program which envisages a move in three to five years will necessarily engender loss of the present faculty and would discourage all granting agencies from supporting growth of the School in its present quarters. Much of Jersey City and Hudson County's population has accepted the Medical School's presence and services; a move would impose a new, time-consuming, and corrosive period of adaptation. Finally, the numbers and variety of patients at the Jersey City Medical Center are ideal for the needs of a medical school of high calibre.

The Future

Perhaps New Jersey's slumbering medical conscience is now awakening! We all look forward to further open exchange of professional views in this and similar journals. These conversations will educate us all to the needs, the means, the costs, and the desires of medicine in New Jersey. With an informed general public, legislature, and medical profession New Jersey could become another proud leader in medical care. Let us all maintain a constructive attitude in the solution of such problems as the continuing education of the practicing physician, the mutually beneficial relation of community hospitals and the university hospitals, the continuing development of productive medical research in New Jersey, and the training of able doctors and medical scientists for the diverse needs of our society.

24 Baldwin Avenue

Prevention of Congenital Toxoplasmosis

The author screened 1,500 pregnant women for possible toxoplasmosis. Serologic tests were performed and 76 were found to have latent toxoplasmosis. They were treated with pyrimethamine and sulfamethazine. The treatment was continued until skin and complement fixation tests were negative for toxoplasma. In the first group of 26 women, treatment was started before the 12th week of pregnancy, and these were delivered of 23 viable infants. In the second group of 42 women, treatment was started between the 12th and 13th week of pregnancy, and these were delivered of 34 viable infants. In the third group of eight women, treatment was started after the 13th week of pregnancy, and only 4 viable babies were delivered, the other four were still-births. After the first course of treatment, urinary pregnandiol was markedly reduced, and it continued to decrease during later courses. To minimize the side reactions of the drugs, the patients were given daily doses of progesterone, intravenous glucose, and multivitamins. The author feels that this is the best method for the prevention of toxoplasmosis in babies.

—S. Zakarchuk, *Akushertvo i Ginekologia* (Moscow) 40:36 (Nov. 1964)

Doctors have always risen to the occasion in preventing the spread of epidemics. Here is one of the most threatening epidemics in human history: death from fall-out.

Facts on Fallout

William A. Dwyer, Jr., M.D./Paterson

It behooves all physicians to enlarge their knowledge of diseases and of agents that can produce disease on a continuing basis. One such agent is radiation produced by x-ray machines, radium, any of numerous isotopes, and by nuclear weapons. We use radium, isotopes, and x-ray on almost a daily basis in medical practice. In this way, we have acquired a considerable body of knowledge regarding both its beneficial and harmful aspects. If casually asked about measures to reduce radiation hazard, there are few among us who would lack the knowledge to answer: erect shielding or increase the distance from the hazard, or both.

The Federal Government is concerned with a possible radiation hazard to the population of the United States. The source of this is the immediate fallout resulting from potential nuclear explosions. The best means of obtaining protection from this fallout radiation is to erect shielding or to increase the distance between the subject and the fallout, or to do both if possible. This has led to the concept of the fallout shelter. A program has been evolved to provide such shelter throughout the country. These shelters are, for reasons explained below, designed only to protect that portion of the total population who are exposed to radiation from early fallout. As such, it is estimated that, in case of need, they would result in the saving of 50 to 70 million lives. Without them, total survivors would be approximately 15 million people. With them, the number would be approximately 80 million.

Confusion about the program has developed due to a variety of factors. First, popular novels have been published depicting nuclear war as the absolute end of mankind. This is based on gross distortion of known fact, and on misconceptions of long and short range effects of radiation and the effective range of nuclear weapons themselves. Make no mistake! Nuclear war, under the best conditions, would be horrible. The number of people killed in this country could well approach 100 million, to say nothing of the extensive property damage and complete disruption of this luxurious way of life we now enjoy. But there would be 80 million survivors (more or less, depending on our ability to prepare for a cataclysm of this sort) who will be left to make something resembling the America we now know and love out of the extensive remainder of the physical resources of the country. The degree of their eventual success will depend, if the event should come, on what we do now to help them.

The effects of delayed, not immediate, fallout have been depicted as causing a "creeping death" effect on initial survivors. We have been exposed to fallout of this type since 1953, and there is much more concern about the population explosion than there is about the trace amounts of Strontium 90 that have been deposited and recorded in our milk and food stuffs. Certainly there is little, if any, evidence of a "creeping death."

Another factor that has complicated understanding of the fallout problem is a misconception about the kind of shelter that is intended. Many people think that these shelters are to be large, blast-and-fireproof underground caves, constructed at fantastic cost and essentially useless unless the entire population

can be regimented. Since the government has taken great pains to utilize existing structures and to emphasize these shelters as protection against *radiation,* this misconception is hard to understand.

If we physicians are to be true to our calling, we must learn all we can about anything that might cause or prevent death. This is especially difficult in this field, not only because of conflicting reports but also because of confusing terminology. We must analyze this threat to life and insist on the adoption of whatever sensible measures exist to protect mankind against it. This we did with smallpox, cholera, typhoid, yellow fever, and many other diseases. We can do no less with this agent, even though it is not bacterial or viral.

Three radiation hazards accompany nuclear explosions. They are:

1. *Initial nuclear radiation* released by the bomb itself and composed of neutrons and gamma rays (both prompt and delayed). Most of this radiation is released in the first second after an explosion. All of it has been released by the end of the first minute.

2. *Early fallout.* When a nuclear explosion takes place close to the ground, the resulting fireball and blast suck up large quantities of debris and dirt into the "mushroom cloud" where they are exposed to various kinds of ionizing radiation. The resultant particles then fall out of the cloud after being carried downwind for a distance. The rate of descent is a function of the weight of the particle and the degree of radioactivity is roughly inversely proportional to the size of the particle. A large particle (200 micra) will settle to earth fairly early but will emit only small amounts of radiation compared to a small particle which settles late but is very radioactive.

3. *Delayed fallout.* This is composed of very small and light particles blown into the stratosphere to descend slowly and erratically in months or years. It is the type of fallout that we have been exposed to continuously over these past years.

The *first type* of hazard occurs only in the area of maximal blast and fire damage. Protection against these modalities would prove more than sufficient protection against the associated radiation. In the event of a nuclear war, casualties within 10 to 15 miles of ground zero will closely approximate 100 per cent of those persons not sheltered against blast and fire. These are the so-called "inevitable" casualties.

The *second type* of hazard will affect an area downwind from the explosion many times larger than that damaged by blast and fire. There will be no damage and no immediate casualties here. Yet, every person inadequately sheltered in this area will be a fatality due to an overdose of radiation. Estimates on the numbers of such casualties runs into the tens of millions: all of them needless deaths.

The *third type* of hazard we are all too familiar with. Indeed, we have been faced with it since 1953 and are well acquainted with its perils in the form of a slightly increased incidence of leukemia and sarcomas of the bone. The amount of radiation from this source is small and of no immediate consequence. It does present a hazard in the long run because of its incorporation into foodstuffs. Adequate long-range planning and monitoring is the only answer to this hazard. Certainly, the continuous monitoring of food supplies and autopsy materials that the Atomic Energy Commission has been carrying out over these years has given them enough data to provide a background for such planning.

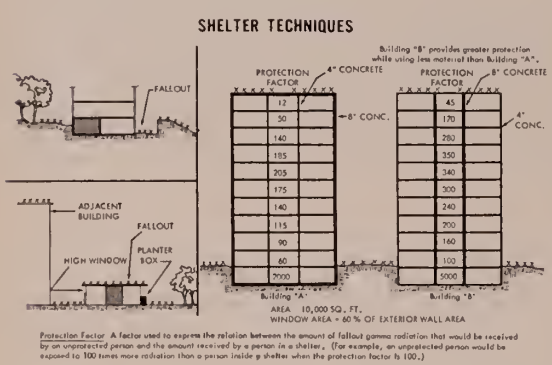
Casualties in the vicinity of ground zero could be lessened by developing a shelter program to provide the maximum possible protection against blast and fire in the vicinity of all possible nuclear weapon targets. A moment's reflection on the distribution of various military, industrial, and population complexes makes one realize that this would mean developing such a program for the entire country. There just isn't any area that doesn't contain some potentially worthy target.

Construction of such a shelter system would cost approximately 20 billion dollars. To make such a system truly effective, the entire population would have to be repeatedly briefed on the location of the nearest underground shelter, drilled in reaching it rapidly at a given signal (remember, warning time until the explosion takes place is 15 minutes), and then educated to accept the discipline necessary to rule large numbers of people

confined in a small space for a prolonged period of time.

It is the opinion of the Department of Defense that the Nike-X antiballistic missile weapons systems can be developed into an effective weapon against ICBMs. Certainly, this would be a preferable way of dealing with the entire problem, both from the standpoint of economics and politics.

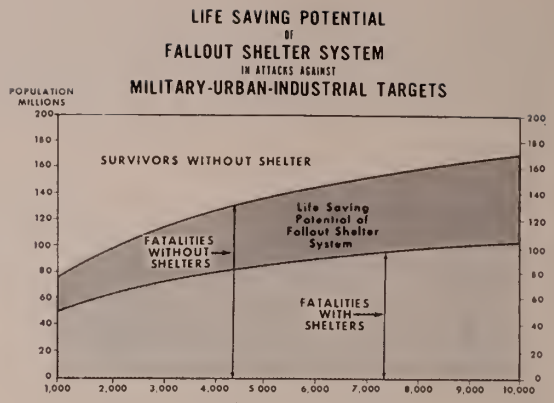
For these reasons, then, *no one in Civil Defense is advocating the construction of any blast-proof shelters in any location. Civil Defense is endeavoring to locate shelter spaces within existing structures,* and to increase the possible number of such spaces in new construction by minor structural modifications. Figure 1 illustrates the use of locations in



Protection Factor: A factor used to express the relation between the amount of fallout gamma radiation that would be received by an unprotected person and the amount received by a person in a shelter. (For example, an unprotected person would be exposed to 100 times more radiation than a person inside a shelter when the protection factor is 100.)

different sized buildings for fallout radiation protection, as well as one minor modification in construction (the use of 8-inch concrete inner walls instead of 8-inch outer walls) that could be of substantial aid in reducing the radiation dose.

Figure 2 shows the potential yield in terms of survivors where an effective fallout shelter system is used. As can be seen, the number of survivors increases by 50 million in a 5,000 megaton attack and in the event of a 10,000 megaton attack the number of survivors is increased by 70,000,000. These are truly staggering numbers of needless deaths, so easily preventable by application of knowledge we all possess, and at a cost of $12.00 per person



In event of attacks against military targets alone, total fatalities would be reduced and life saving potential of shelters would be increased.

SOURCE: Composite of damage assessment studies by Department of Defense

sheltered, and an estimated $15.00 per life saved.

The Nike-X system seems promising—and will provide adequate protection to those areas where it is deployed—against the immediate effects of nuclear explosions. Figure 3, however, depicts the kind of situation that could arise. Here a number of ground bursts away from the metropolitan area, but downwind, are shown depositing a blanket of radioactive fallout within the protected area.



It is this reason, among others, that has led Secretary of Defense McNamara to state:

"A fallout shelter program can stand alone and be justified independently of an anti-ballistic missile system, and it should be given priority over such a system. But an antiballistic missile system cannot stand alone without a fallout shelter program."

One last factor must be considered in our analysis. It is possible that these weapons could be exploded at a high rather than low altitude, thus eliminating the fallout completely. This would considerably cut down

the number of eventual casualties, but it is, at best, only one alternative the enemy might employ. It is up to us to make it unprofitable for him to try ground bursts.

This fallout shelter program proposed by Civil Defense complements defensive weapons systems being developed, is of modest cost, and fits into the pattern of our democratic way of life. It is an effective protection against radiation alone and, as such, may some day save millions of lives. It is based upon knowledge and experience we of the medical profession are utilizing on a daily basis in our practice.

Radiation hazard in the form of immediate fallout is a life-threatening agent, ranking far above even the worst disease pandemics of history. Like most of the agents which produced these pandemics, this, too, is an agent against which preventive measures can be taken. We can do no less than strongly advocate that they be taken.

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The author wishes to acknowledge his indebtedness to the following for their help in preparing this manuscript: Philosophical review and comment by Dr. Paul Ferrary; scientific analysis of data by James M. Dwyer, Ph.D.; legal review, by Mr. Arthur C. Dwyer, L.L.B.; and the practical woman's viewpoint by Mrs. William A. Dwyer, Jr.

412 Park Avenue

Paintings of Medical Colleges

A long-range plan to create a collection of original oil paintings of the medical colleges of America was recently launched with the unveiling and presentation of The Jefferson Medical College of Philadelphia painting to its dean, William A. Sodeman. The project, sponsored by E. R. Squibb & Sons, one of the country's leading pharmaceutical manufacturers, is known as *Collegia Medica Squibb*. It will continue until representative paintings of all 83 medical schools have been completed.

The first painting shows the main entrance of the school on Walnut Street and is the work of Ben Eisenstat, associate professor at the Philadelphia Museum College and an instructor at the Museum of Art.

Mr. Stock stated, "The Bicentennial of Medical Education in America is being celebrated this year." "Squibb," he added, "offers the 'Collegia Medica' in recognition of the world's greatest system of medical education."

Mr. Squibb, in making the presentation to Dean Sodeman, said that "since more physicians practicing today graduated from Jefferson than from any other medical college, it is natural that this great institution be chosen as the first subject of this enduring program." "It is also natural," he continued, "that we at Squibb are justly proud that our founder—my great-grandfather, Doctor Edward Robinson Squibb—received his Doctorate of Medicine degree at Jefferson over a century ago."

The *Collegia Medica* program has been undertaken after consultation and discussion with the three organizations most intimately concerned with medical education: the American Medical Association, the Association of American Medical Colleges, and the Student American Medical Association.

STATE ACTIVITIES

Trustees' Minutes

February 24, 1965

A regular meeting of the Board of Trustees was held on February 24, 1965, at the Executive Offices. For the information of the membership, detailed minutes are on file with the secretary of each county society. A summary of the significant actions follows.

Governor's Conference on Aging . . . Approved the action of the Executive Committee in accepting the Governor's invitation to The Medical Society of New Jersey to be a participating organization for the second Governor's Conference on Aging, to be held in Trenton on April 27th.

New Jersey Public Health Association . . . At the request of the Association to name a Chairman of its Medical Care Committee, appointed Doctor John J. Bedrick of Bayonne.

Professional Corporations . . . Received and noted the following report from legal counsel:

An extract from the February 5, 1965, *Kiplinger, Washington Letter* indicates that the Internal Revenue Service, in an unpublicized action, is determined that physicians cannot set themselves up as corporations for tax purposes. In spite of the fact that states, like New Jersey, have already passed special laws for that particular purpose, IRS will not recognize pension plans of professionals who have incorporated.

Forged Drug Prescriptions . . . At the request of the State Board of Medical Examiners of New Jersey—which reported that 30 to 40 forged prescriptions for narcotics and barbiturates were picked up by the Bureau of Inspectors over a weekend—we are asking our members to:

1. Omit from their printed prescription blanks their narcotics registration number. The doctor, of course, will be obliged to insert his narcotic number in writing on the prescriptions which require it.
2. Avoid leaving prescription pads about their offices, easily accessible to theft.

Special AMA Session . . . Accepted the following report of the 1965 Special Session of the AMA House of Delegates.

A special session of the House of Delegates of the American Medical Association was held in Chicago to review current proposed national health legislation, to determine the position of organized medicine with reference to that legislation and to agree upon the educational program to achieve the defeat of unsatisfactory measures and the adoption of satisfactory ones.

In consequence of its recently attained new total of more than 6,000 members of the American Medical Association, The Medical Society of New Jersey was represented by seven delegates: Drs. C. Byron Blaisdell, Joseph P. Donnelly, Marcus H. Greifinger, Frank J. Hughes, Jesse McCall, Luke A. Mulligan, and Isaac N. Patterson. Also in attendance as official representatives of the Society were Drs. Charles H. Calvin, President; John J. Bedrick, President-Elect; Jerome G. Kaufman, alternate delegate; and Mr. Richard I. Nevin, Executive Director.

The House of Delegates gave unanimous support to the Herlong-Curtis Eldercare Bill (H. R. 3727) as embodying the basic principles of the AMA program.

H. R. 3727—known as the "Eldercare Act of 1965"—would amend Title I (Old Age Assistance and Medical Assistance for the Aged) and Title XVI (Aid to the Aged, Blind, or Disabled, or such aid and medical assistance for the aged) of the Social Security Act, to add a new section under which a state with an MAA program would be authorized, in its discretion, to provide Medical Assistance to the Aged in the form of premium payments for health insurance coverage under voluntary private health insurance plans in addition to providing assistance in the manner authorized under existing law. A state wishing to participate in the program would be required to enter into contracts or other arrangements with private insurance carriers as it deems appropriate.

The Herlong-Curtis bill, therefore, would authorize federal grants to the states on a matching basis to help persons 65 years of age and older to pay the costs of the health insurance or prepayment coverage if they could not afford it otherwise. The bill would provide for utilization of Blue Cross and Blue Shield plans and private health insurance companies.

The cost of such coverage would be borne entirely by government for those elderly persons whose incomes fall below "reasonable" limits set by each state. For persons with incomes between the minimum and the maximum thus set, government would pay a part of the cost, on a sliding scale according to the individual's income. Those with incomes above the established maximum would pay the entire cost, but they would have the benefit of an income tax deduction for such payments.

Besides its unanimous vote in approval of H. R. 3727, the House of Delegates:

1. Reaffirmed its opposition to the King-Anderson bill (H.R. 1 and S. 1) and all similar measures;

2. Commended the Board of Trustees and its Task Force for its program of public education on the AMA Eldercare Program and gave them a vote of confidence;

3. Called for study of the "desirability and feasibility of extending the principle of federal and state aid under the Kerr-Mills principle to persons below the age of 65 who need it";

4. Adopted a statement on Standards for Health Care Programs; and

5. Urged that the professional services of pathologists, radiologists, physiatrists, and anesthesiologists should be excluded from the provisions of any bill which excludes other physicians' services.

Dr. Percy E. Hopkins, Chairman of the Board of Trustees, reported to the House that the AMA's current effort to tell its story to the people and to the Congress is being financed through the allocation of a portion of the Association's reserve fund. In response to a number of questions raised during the open discussions, the delegates also were told that the education program will not require a dues increase or a special assessment. The program will be national in scope—involving magazines, radio, and television—but maximum grass roots effort was urged upon the entire AMA membership and the Woman's Auxiliaries.

The House passed a resolution reaffirming earlier positions established on federal medical care programs. Included was the reaffirmation of the policy which urged component associations to stimulate state and local governments to seek the fullest possible implementation of existing mechanisms, including the voluntary health insurance principle, to the end that everyone in need, regardless of age, is assured that necessary health care is available.

Society Committee Structure . . . Approved the following recommendations of the special committee appointed by the Board—by action of the 1964 House of Delegates—to study the special committee structure of the Society, "with the thought in mind of streamlining the number of committees when their function seems to have lost substance."

1. That the three special committees be merged into one special committee on Occupational Health, Rehabilitation, and Workmen's Compensation, to the Council on Medical Services— merger to begin with the new administrative year, 1965-66—and that, if necessary, the membership of the new committee be expanded beyond the usual limitation of 12.

2. That the following special committees to the Council on Public Health be continued as single committees: Cancer Control, Child Health, Chronically Ill and the Aging, Maternal and Infant Welfare, and Mental Health.

3. That consideration be deferred on the following general special committees: Disaster Medical Care, Medicine and Religion, Retirement Plan for Physicians, and Traffic Safety.

4. That the Board carefully review the functions of the numerous special committees which it has appointed —some of which have been carried over from previous years, with the thought of combining those having similar interest, or transferring their duties to councils or general special committees, thus eliminating those Board committees which no longer have significant function.

Assigned to the presently functioning study committee the careful review of the Board committees (as outlined in 4 above) to report recommendations in the future.

Industrial Eye Screening . . . Approved as a pilot study in 1965 that Western Electric be encouraged to conduct an Eye Health Screening Program in conjunction with and during "Eye Health Week."

Protective Goggles . . . Referred to the Special Committee on Child Health the recommendation that

MSNJ investigate and select the proper means to effect the adoption and use of goggles or protective eye glasses by students in school situations that might endanger their eyes if unprotected.

Maternal Death Definition . . . Approved the AMA definition of "Maternal Deaths" as follows:

The death of any woman from any cause whatsoever while pregnant or within 90 days of the termination of the pregnancy, irrespective of the duration of the pregnancy at the time of the termination or the method by which it was terminated.

Medical Examiners' System . . . Received the Governor's assurance that he will bring to the attention of appropriate state officials the Society's desire to abolish the existing county coroners' system.

Medical Technicians . . . Noted the introduction in 1965 of the Society's bill:

S-179—Dumont. Farley—To afford legal protection under the Medical Practice Act to medical technicians and x-ray technicians carrying out procedures at the specific direction of a licensed physician. *Active Support*

State Legislation . . . Considered the following bills of medical import and took the actions indicated in italics. All bills marked (*) are identical with measures of last year—or preceding years—whose positions were the same.

*S-42 —To provide that no chemical analysis or speci-
*A-321—men of a defendant's blood may be taken in drunken driving cases against the physical resistance of such defendant. *Approved*

*S-51 —To require seat safety belts on automobiles
*A-314—registered, sold or operated in the state after July 1, 1965. *Approved*

*S-54 —To prohibit, as a disorderly person offense, the smelling or inhaling, or sale for such use, of glues capable of releasing toxic vapors causing intoxication, inebriation, excitement, or stupefaction; exempts anesthesia for medical or dental purposes, and model kits. The Council recognized the inherent danger in glue sniffing and approved the principle embodied in the bill. However, it is the Council's opinion that the danger cannot be curtailed by legislation, but that control should be exercised at local level. *No Action*

S-61 —To increase the membership of the hospital licensing board to 6, and requires the appointment of one member selected from among the official boards and administrators of the several non-profit homes for the aged. *Approved*

S-63 —To amend the law regulating the disposition by an individual of his remains. *Approved*
This bill was identical to a draft proposed by MSNJ in 1962. In 1963, legislation was introduced "to permit a person to will his eyes to medical science for humanitarian purposes." At that time the Society did not press for expansion of the bill to include disposition of all, or any parts of, the body because Assemblyman Beadleston (who sponsored the bill) felt it was important to get the "eye bank" legislation through first. This subsequently became Chapter 154 of 1963.

S-69 —To require motor vehicles after June 30, 1966,
A-137—to be equipped with crankcase ventilating systems of a type approved by the Air Pollution Control Commission. *Action Deferred . . .* pending study and recommendation from the Subcommittee on Air Pollution.

S-72 —To prohibit the expenditure or allocation of public funds and the provisions of public facilities for the support of, or in aid of, activities or programs from the benefits of which anyone is excluded for reasons of race, creed, color or national origin. *Approved*

S-83 —To increase State competitive scholarships from $400 to $500 per year; includes schools of professional nursing within the category of accredited colleges. *Approved*
This measure had passed in the Senate on February 1 and was reported to be going through the Assembly on February 15 (which subsequently it did). Because of the Society's interest and concern in the nursing shortage, as expressed in the Permanent Committee on Nursing Education and Recruitment, it was important that MSNJ be on record as favoring this measure before it became an accomplished fact. Therefore, under the emergency mechanism established for such purpose, the Society's position of "approval" was cleared. A letter from the President of MSNJ was sent to members of the New Jersey Assembly on February 11 recording MSNJ as approving S-83: "The Society regards this bill as a constructive step forward in the effort to overcome the present critical shortage of nurses in New Jersey."

S-86 —To permit the Department of Health or any local board of health to direct the destruction or removal of wild or passenger pigeons if it finds that the presence of such pigeons in hazardous to the health of any state inhabitant. *Approved*

*S-94 —To provide that any resulting disease of the
*S-95 —respiratory system of a member of a paid fire
*S-96 —or police department shall be deemed an occupational disease. *Disapproved . . .* because they involve diagnosis by legislative enactment rather than by medical investigation.

*S-98 —To broaden the protection afforded employers
*A-176—in second accident prior disability cases under the Workmen's Compensation Act. *Approved*

*S-106—To define packaged medicines which may be sold by general merchants. *Disapproved . . .* because the council is of the opinion that Section 2 of the measure empowers the manufacturer to determine what is non-poisonous. This section declares: ". . . the term 'non-poisonous' shall mean and include those preparations which are not dangerous to health when used in the dosage, or with the frequency or duration prescribed, recommended, or suggested in the labeling thereof." The council considers that it is unwise and undesirable and contrary to the public interest that the manufacturer be the sole arbiter of what is "non-poisonous." Moreover, MSNJ looks with disfavor on any legislation which would relax the salutary controls necessary for the protection of the public and which would tend to encourage self-medication on the part of the public.

S-143—To designate the "State Public Sanitary Sewerage Facilities Assistance Act of 1965," authorizes State financial assistance for the planning of public sanitary sewerage facilities. *Action Deferred . . .* pending study and recommendation from the Council on Public Health.

*S-145—To include under the scope of laws dealing with the practice of optometry any who offer and market for sale at retail to the general public spectacles or eyeglasses containing other than plano lenses. *No Action*

S-150—To designate the "State Health Aid Act of 1965;" provides for a program of State aid to local health agencies to establish and maintain a program of recognized public health activities. *No Action*

*S-169—To provide for adjustment of contract rates of hospital service group contracts under experience rating plans approved by the Commissioner of Banking and Insurance. *Approved*
*S-170—To provide for adjustment of contract rates of medical service group contracts under experience rating plans approved by the Commissioner of Banking and Insurance. *Approved*

S-171—To exempt from taxation air and water pollution control equipment facilities and devices certified by the State Commissioner of Health. *Approved*

A-2 —To amend of the Unemployment Compensation Act to provide a scale of benefits equal to ⅔ of a claimant's average weekly wage, maximum of 60% the first year and 66⅔% thereafter; repeals the "active search for work" provision, provides an alternate method of establishing eligibility; provides full coverage for employees where employers employ 1 or more, immediate coverage for employers who elect coverage pursuant to a collective bargaining agreement; effective on the 1st day of January following the adoption of this act. *No Action*

*A-3 —To permit an injured employee to select the physician he wishes to treat him under the Workmen's Compensation Act. *Approved.*

A-5 —To revise the Workmen's Compensation Law and to increase weekly and other compensation. *No Action*
In discussing this measure, the council noted with satisfaction that it embraces a principle which MSNJ has long recommended: that the workman have a right to select the physician he wishes to treat him under workmen's compensation. However, since the bill is voluminous and deals almost exclusively with matters of a fiscal nature, the council concluded it was not proper to Society interests. Its final recommended position, therefore, was one of "no action."

*A-8 —To authorize the Commissioner of Banking and Insurance to disapprove and determine the rate of payment to a participating physician under a medical service corporation or medical service plan. *Active Opposition* . . . because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by MSP to participating physicians and would therefore constitute an unwarranted and unjustifiable denial of the fundamental right of the physician to set his own fee for professional services rendered, thus threatening the operation of the Plan, in disregard of the best interests of the approximately two million people of New Jersey who are its subscribers.

*A-33 —To establish presumptions in certain illnesses of firemen and policemen. *Disapproved* . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-39 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease, or tuberculosis shall be deemed to be an occupational disease. *Disapproved* . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

A-56 —To presume, as a condition for a license, implied consent of car drivers to the taking of samples for the purpose of making chemical tests to determine the amount of alcohol in the blood where there is "reasonable" cause to believe that the person to be tested is under the influence of alcohol; effective on the 91st day following enactment. *Approved*

*A-59 —To limit the subrogation rights of insurance companies, or medical or hospital service corporations, with respect to third party recoveries for hospital or medical services. *Disapproved* . . . because the Society is on record approving the opposite principle, as contained in S-4 of 1963.

A-78 —To amend the Workmen's Compensation law to provide that whenever hospital services are required to cure or relieve an injured workman, he shall be entitled to hospital service of a quality and character no less than provided for patients receiving services known as "semi-private" room care. *Disapproved* . . . because it is based on the unsound premise that the quality of medical and nursing care in hospitals is controlled by the expensiveness of the accommodations.

*A-127—To make technical amendments in various statutes dealing with mental incompetents and their guardians. *Approved*

*A-128—To propose a general revision of the laws governing mental health, designated as "The Mental Health Act of 1965;" effective January 1, 1966. *Approved*

*A-129—To amend the law governing persons confined to institutions by court order, and to require persons admitted to the state sanatorium for convalescence from tuberculosis or respiratory disease be liable for care costs in the same manner and extent as required from mentally ill or retarded persons or relatives; effective January 1, 1966. *Approved*

*A-138—To revise the statutes concerning the practice of pharmacy and the regulation and control of the sale and distribution of drugs, medicines, and poisons. *Approved*

*A-169—To create a Division of Refuse Control in the Department of Health to regulate and license the collection and disposal of solid waste. *Disapproved* . . . in support of the position of the Health Department that the legislation is unnecessary and undesirable.

*A-180—To provide for the registration and examination of dental laboratory operators and their assistants by the State Board of Registration and Examination in Dentistry. *Disapproved* . . . in support of the position of the New Jersey State Dental Society, which contends that the bill is loosely drawn.

*A-204—To extend the time for filing petitions under the Workmen's Compensation Act in cases of exposure to ionizing radiation *Approved*

A-248—To prohibit as a misdemeanor the selling of any glue, liquid cement or other similar substance which does not contain an irritant or nauseant; effective January 1, 1966. *Disapproved* . . . because it would pose an unjustifiable hazard for all those who must use such materials regularly.

*A-271—To amend the Absentee Voting Law to eliminate the need for a physician's certificate in connection with an absentee ballot for temporary disability. *Disapproved* . . . because it would encourage self-diagnosis.

A-280—To prescribe new penalties for operating a motor vehicle while the ability to operate such motor vehicle is impaired by the consumption of alcohol, provides that the presence of 0.10% or more weight of alcohol in the defendant's blood would create a presumption of impairment. *Approved* . . . with reference to the standards of percentile ratio of alcohol by weight to establish the presumption of impairment, but without commitment as to the fairness of the penalties declared.

A-325—To prohibit as a disorderly person one who wrongfully obtains or attempts to obtain or procure the administration of amphetamine, barbiturate, barbital, hypnotic or somnifacient drugs, tranquilizers or any prescription legend drug. *Disapproved* . . . because, in view of the enactment of A-42 of 1964, Chapter 225, this legislation seems unnecessary and redundant.

A-338—To provide that the State Department of Health, its officers, agents, inspectors and representatives, and all peace officers and county prosecutors shall enforce all provisions of law concerning amphetamine, barbiturate, barbital, hypnotic or somnifacient drugs, tranquilizers or any prescription legend drug. *Disapproved* . . . because, although the purpose of the bill is good, the council is of the opinion that the responsibility involved should rest with the Board of Pharmacy in the Division of Professional Boards.

A-365—To require every person selling any article of food which has been frozen and permitted to thaw to label the package or container stating "This article of food was frozen and permitted to thaw;" effective 60 days after enactment. *Approved*

*A-370—To prohibit the discharge of pollutant matter or materials into inland tidal waters and to regulate the operation of toilet facilities in vessels in said waters. *Approved*

*A-379—To provide that any person who shall hypnotize or attempt to hypnotize another person for purposes of entertainment is a disorderly person. *Approved*

A-388—To prohibit any insurance company to issue any contract of accident or health insurance when such contract excludes payment of benefits in whole or in part to the individual, his spouse or dependents, where the insured individual or his spouse or dependents are eligible under any other contract of accident or health insurance; without providing for an appropriate reduction or elimination of premium payments. *Action Deferred* . . . pending referral for comment by Hospital Service Plan of New Jersey.

*A-421—To require a copy of the results of a breath and chemical test be given to a person accused of drunken driving, to permit the person tested to have the tests made by a person of his own selection; presumes that the refusal of a person to take a test would have an illegal percentage, by weight of alcohol, in the blood. *Approved*

*A-434—To provide that eligible persons may continue to receive assistance for the blind while in certain medical institutions; effective July 1, 1965. *Approved*

A-467—To provide for the preparation of students for general practice in the professions of medicine and dentistry. *Approved*

*A-481—To amend the act regulating nursing; reduces the age for professional nurse candidates from 20 years to 18 years; raises fees for examinations and registration. *Approved*

*A-489—To transfer certain approval powers over hospital service corporations from the Commissioner of Institutions and Agencies to the Commissioner of Banking and Insurance. *No Action*

*A-491—To provide that a licensed sanitary inspector first class who has serve das a municipal health department executive officer for one or more years shall be qualified to take the examination for a health officer's license. *Disapproved* . . . because it is special legislation, discriminating against the public interest in favor of an individual.

A-499—To regulate the practice or profession of removing superfluous hair from the body through registration and licensing of electrologists by the Board of Medical Examiners. *Approved*
The council noted that this bill is an amended version of A-218 of 1964, and embodies the suggestions made by MSNJ as well as those of the New Jersey Dermatological Society. Thus the objectionable features of last year's bill (A-218) have been eliminated.

A-502—To provide that a drug addict who uses any child under 18 years of age to carry or sell drugs is guilty of a high misdemeanor. *No Action*

A-508—To require every board of education to employ a school nurse. *Disapproved* . . . because it is mandatory not permissive; because such services are already provided under existing law by qualified nursing personnel; and because of the present limited supply of professional nurses in New Jersey.

Automobile Safety . . . Approved the following recommendations of the Special Committee on Traffic Safety:

1. That The Medical Society of New Jersey urge the installation of seat belts in both front and rear seats of all passenger vehicles.

2. That the Board of Trustees urge all members of The Medical Society of New Jersey to install and use front and rear seat belts in their cars and to be at pains regularly to use such seat belts as an example to the members of the public.

3. That The Medical Society of New Jersey having adopted the two preceding recommendations, invite the Bar Association, Nurses Association, Congress of Parents and Teachers, and members of the Woman's Auxiliary to cooperate in carrying out the same recommendations.

4. That The Medical Society of New Jersey request the Department of Purchase, State of New Jersey, to specify adequate safety facilities in vehicles purchased by the State for official use, in agreement with standards currently being developed by the General Services Administration, purchasing agent for the Federal Government.

Kerr-Mills . . . Approved the following recommendations of the Committee on Chronically Ill and the Aging toward improvement of the Medical Assistance for the Aged program in New Jersey:

1. That the responsible relatives provision, in line with the philosophy of the AMA on the MAA program, be eliminated from the law.

2. That the investigation process be minimized and to that end, that a simplified attestation of annual income be accepted by the State as the basis for determination of financial need, and that the Bureau

or Division or physicians encourage potential beneficiaries under this program to establish eligibility for MAA benefits in advance of their medical need.

3. That no action be taken on the suggestion that the MAA program be taken out of Title 44 ("Poor Act") and be carried out by another agency, since the existing facilities are perfectly adequate.

4. That the suggestion—to modify the law to allow people who qualify under it to obtain medical care from a physician of their choice, while in the hospital as a MAA patient—be disapproved, because it would be contrary to the prevailing pattern of hospital care of the patient who is in war service status, such as the New Jersey MAA recipient.

5. That no action be taken on the abolition of lien laws, inasmuch as the committe recommended that the responsibility of children in relation to MAA be no longer retained.

Seton Hall . . . Affirmed the stand of the Hudson County Medical Society strongly objecting to the summary dismissal of 10 faculty members by the Dean of the Seton Hall College of Medicine.

March 21, 1965

A regular meeting of the Board of Trustees was held on March 21, 1965, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Cardiopulmonary Resuscitation . . . Appointed a special committee—to cooperate with the New Jersey Commissioner of Health, the New Jersey Hospital Association, and the New Jersey State Nurses' Association—to study the closed chest method of cardiopulmonary resuscitation as an emergency measure and to arrive at a joint policy statement about it. The committee consists of:

Dr. Philip J. Kunderman, New Brunswick
Dr. William E. Philip, Morristown
Dr. George N. J. Sommer, Jr., Trenton

Major Medical Insurance . . . Approved the recommendation of the Committee on Medical Defense and Insurance urging:

. . . that Mr. Blanksteen consider the idea of amending the policy to provide 50% payment of the daily nursing fee; and that Mr. Blanksteen also consider issuance of two coverages (1) basic policy excluding nursing care, and (2) for a reasonable additional fee, a rider or separate policy to include unlimited nursing care.

Additional Insurance . . . Approved the action of the Committee on Medical Defense and Insurance in exploring with Mr. Blanksteen the possibility of periodic open enrollment periods on non-selective basis for accident and health insurance, to accommodate young physicians who might not be able to purchase all of their insurance when beginning practice.

Rehabilitation Fees . . . Approved the recommendation of the Council on Medical Services that the Special Committee on Rehabilitation work with the Rehabilitation Commission in an effort to develop a more realistic fee schedule.

National (AMA) Programs . . . Approved the following report and recommendation of the Council on Public Relations:

Because of its recommendations at the preceding meeting concerning AMA national educational programs, the council reviewed the disposition of MSNJ's Resolution #18 on this subject, prepared at the direction of the Society's Board of Trustees for introduction at the AMA session in Miami Beach.

The council expressed its concern that this resolution received a position of "no action," at the recommendation of the AMA reference committee to which it had been referred. It was the unanimous opinion of the council that the purpose of Resolution #18 was to establish on the record a policy requiring that the AMA not commit itself to national programs without first giving constituent associations the opportunity of discussing and formally concurring in proposed national programs.

The council recalled that the AMA was quite vocal in recording the success of the special conference of representatives of all constituent associations called by the AMA Board of Trustees December 13, 1964 in preparation for a new national educational program. In view of this, the council was convinced that the AMA Board of Trustees would be in position to support a resolution requiring the holding of such meetings as a matter of policy.

The council therefore unanimously *recommended* that the "whereas" sections of Resolution #18 be up-dated; and, as revised, the resolution be introduced by The Medical Society of New Jersey at the AMA meeting in June (New York City).

Health Careers Booklet . . . Approved the action of the Council on Public Relations to underwrite for the Woman's Auxiliary (at a cost of $93.25) additional listings in its "Guide to Health Careers in New Jersey in

the Medical and Para-Medical Fields" to include the careers of physical therapy, veterinary medicine, medical records librarian, and medical secretary.

County Presidents . . . Received the following report concerning the discussion of county presidents at their second annual conference:

1. *Future Meetings*

The morning session was very profitable. The group made the following suggestions for future meetings:

(1) That the President and the President-Elect of each component society be invited, and that it be urged that at least one of them attend.

(2) That two meetings a year be continued—one in the fall and one in the spring.

(3) That "board room" arrangements be provided.

The group requested Dr. Pflum to attend the first meeting in 1965-66, even though he will not be President of his component society at that time, to open the meeting and chair the election of a new presiding officer.

2. *Emergency Medical Services*

The Union County system was described in detail by Dr. Pogue, who was commended for the progressive steps taken in his county. It was agreed that emergency medical service coverage is a local problem, and there was some advertence to the fact that some counties do not have any such coverage and suggestion was made that they attend to this matter promptly.

3. *Insurance Coverage*

The following questions were asked concerning the Society's insurance plans:

(1) Upon admission to associate membership, are physicians entitled to all insurance coverages?
(2) If a member retires, is he still eligible for insurance coverages?
(3) If a member is suspended or dropped from membership, is he entitled to continuance of his insurance coverages?

Dr. Featherston, Chairman of the Committee on Medical Defense and Insurance, replied to the above:

(1) Yes, upon admission to associate membership, a physician is entitled to all insurance coverages.
(2) The insurance plans for accident and health and accidental death and dismemberment are subject to termination at the next renewal date following the retirement of a member.

Dr. Featherston pointed out that this question was answered in the October-November 1964 issue of the *Membership News Letter.*

(3) Upon notice from the Executive Offices to the insurance carriers that a physician has been suspended or dropped from membership, his insurance policies are subject to termination at their next renewal dates.

4. *Associate Membership*

Chapter XI, Section 4 (a) , of the State Constitution and Bylaws reads: Except in the case of transferred membership, each component society must require applicants to serve a probationary period of one (1) to two (2) years as associate members.

Some component societies require associate members, during this probationary period of one or two years, to attend a specified number of meetings, and to serve with the emergency call system. If an associate member does not fulfill these obligations he is considered to be ineligible for advancement from associate to active membership at the end of the probationary period. Can the component society require such physician to repeat his period of associate membership, or must he be dropped? If the latter, is the physician eligible to reapply at a later date for membership, and if so, what membership classification would he apply for?

The Trustees agreed that associate membership longer than a two year period would be improper, and that if an associate member does not fulfill his obligations he should be dropped at the end of the probationary period. In the original writing of the Bylaws it was intended to insure a probationary period of associate membership and that this problem was not contemplated; therefore, the matter should be referred to the Committee on Revision of Constitution and Bylaws for study and possible amendment.

Essentials of Internship . . . Referred to the New Jersey delegates to the AMA the following communication from the New Jersey State Society of Anesthesiologists—with the request that MSNJ support such a program and instruct the New Jersey delegates to the AMA to have this resolution put into effect:

The AMA Council on Medical Education has proposed the following statement be included in the Essentials of Internship:

The resources of the Department of Anesthesiology should be utilized in the instruction of all interns in the fundamentals of emergency resuscitation and the treatment of respiratory and circulatory depression. In addition, instruction in the fundamentals of basic anesthesiology, including the preparation of the patient for anesthesia, as well as the supervised management of the anesthetized patient should be available to all interns, since such an experience will contribute significantly to many careers in medicine.

Student AMA . . . Authorized a contribution of $400 to the New Jersey College of Medicine Chapter of the Student AMA.

New Jersey Academy of Medicine . . . Referred to the House of Delegates a resolution from the Academy of Medicine of New Jersey, requesting continued support of its activities, with the Board's recommendation that a contribution to the Academy in 1966 be the same as that adopted by the House for 1965.

OBITUARIES

Dr. Albert D. Greene

A linear descendant of the famed Revolutionary War General Nathaniel Greene, Dr. Albert D. Greene, one of this Society's oldest members, died on March 11, 1965. Born in New York's Mohawk Valley area in 1886, he received his medical degree from Cornell in 1909. He came to New Jersey in 1910 to intern at the Christ Hospital in Jersey City. Dr. Greene was a family doctor, and served as such for more than 50 years. He was the Senior Surgeon to the Union City Fire Department for three decades. He was also physician to the local Council of the Knights of Columbus. In 1959 he received the Golden Medical Award of our Society. Dr. Greene retired in 1963.

Dr. Julius Klein

A heart attack on February 1, 1965 took the life of Dr. Julius Klein, a prominent member of the Hudson County Medical Society. Born in Bayonne in 1907, Dr. Klein received his M.D. at St. Louis University Medical School in 1932. He interned at the Jersey City Medical Center, and then entered private practice. He served as a family doctor to the people of Hudson County for over a quarter of a century. His office was in Union City and he was on the staff of the North Hudson Hospital in Weehawken, where he was an associate attending internist.

Dr. Stephen Lesko

Physicians are urged to be more active in civic affairs. Many remain aloof. But one of the best representatives of a medical doctor who took his civic responsibilities seriously was Stephen Lesko, M.D. His death on January 18, 1965 ended an unusual career of public service. Born in Bergen County in 1901, he received his M.D. at Bellevue in 1928. He was chief of surgery, and had been president of the medical staff, at St. Mary's Hospital in Passaic. He was school physician and health officer of Wallington borough on various occasions. In 1941 he served as a Bergen County member of the New Jersey assembly. Dr. Lesko was one of the early developers of the Wallington-Carlstadt area in Bergen County. He was active in fraternal and church affairs and was generally considered one of the leading citizens of his area.

Dr. Joseph Matera

Dr. Joseph Matera, one of Hoboken's best known and most beloved figures, died on March 5, 1965. On March 1, a woman timidly entered his office, said she was in pain but hesitated to bother him because she had no money, "Sit down," he said quietly, "I am a doctor, not a business man." And a doctor he was! For a half century he served the people of Hudson County. Born in New York in 1888 (on the night Benjamin Harrison was elected President of the USA), he earned his M.D. at Bellevue in 1916. After interning at the University Hospital, he was asked to become plant physician at the Bethlehem Steel Company, then just beginning its tremendous expansion to make the tools of World War I. After that service he came to Hoboken and engaged in general practice there until the day of his death. He was a health commissioner, a school physician, a police surgeon at various times. But above all, he was a family doctor in the old tradition.

Dr. Frederick L. Muller

On February 25, the town of Carlstadt lost its senior practitioner, with the death that day of Dr. Frederick L. Muller. A 1925 graduate of Columbia University's College of Physicians and Surgeons, Dr. Muller was, for 15 years, treasurer of the Bergen County Medical Society. He was also a member of the House of Delegates of The Medical Society of New Jersey and an Elder of the Presbyterian Church in Carlstadt. He served his internship at the Hackensack Hospital and was a medical "attending" there at the time of his death. Dr. Muller was 66 years old at the time of his death.

BOOK REVIEWS

Diseases of the Chest. H. Carwin Hinshaw, M.D. and L. Henry Garland, M.B. 2nd Edition. Philadelphia, 1963, Saunders. Pp. 798 illustrated ($20.00)

When two of the nation's leading physicians, one an internist the other a radiologist, combine forces to write about an important field of medicine, reviewers have cause to rejoice. Such is the case in this second edition. Hinshaw and Garland have written an extraordinarily detailed text on pulmonary diseases. Although the heart lies within the thoracic cavity, this book is concerned with lung disease and not with cardiology. Except for three chapters written by associate physicians, the entire opus is the work of these two authors.

Radiologic anatomy is detailed and a discussion of artifacts is included. Segmental anatomy of the tracheobronchial tree (as outlined by bronchography) is carefully explained and illustrated. One chapter offers a detailed description and evaluation of pulmonary function studies. Other sections cover the pneumonias, pulmonary abscess, pulmonary fibrosis, bronchiectasis, bronchitis, emphysema, and foreign bodies in the larynx and bronchial tree. Thoracic injuries and diaphragmatic diseases are described. Also reviewed are bronchial asthmas, mediastinal diseases, and bronchogenic carcinoma. This starts with a timely discussion of the latter's relationship to smoking. Also described are pulmonary heart disease, pulmonary embolism, congenital anomalies, tuberculosis, and the entire gamut of pulmonary disease. No current aspect of pulmonary disease is omitted in this superb text. The illustrations are outstanding in their clarity. Where the x-ray itself does not tell the full story, line sketches are superimposed or added to the illustrative material.

This text can be heartily recommended to every physician who deals with diseases of the chest. The authors and publishers are to be congratulated for such an outstanding contribution to the current medical literature.

ROWLAND D. GOODMAN, 2ND, M.D.

The Student Physician as Psychotherapist. Edited by Ralph W. Heine. Chicago, 1963, University of Chicago Press. Pp. 241. ($5.00)

The University of Chicago has tried to develop a new psychiatric curriculum in its medical school. In addition to the conventional teaching, the student gets an unusual opportunity to do individual psychotherapy. This is carefully supervised and reviewd by faculty members. This book is a dissection of that project and includes a good deal of verbatim recording with annotations by the editors. The text is of only minimal value to physicians outside the area of psychiatry, but should be a valuable guide to medical students who, by reading this, will at least get a glimpse of what goes on in the minds of their mentors.

TERRENCE A. CRONING*
PAUL G. CORRAO*

*The reviewers are senior students at Seton Hall College of Medicine.

Clinical Investigation in Medicine. Edited by Irving Ladimer, S.J.D. and Roger Newman, LL.B. Boston, 1963, Law-Medicine Research Institute. Pp. 516.

In developing research and investigation in medicine, there is need for a set of guide-lines on the legal, moral, and ethical aspects of such activities. This anthology is precisely such a code. It was spark-plugged by a grant from the U.S. Public Health Service and another from the Schering Foundation here in New Jersey. Major credit for the enterprise goes to the unique Law-Medicine Research Institute at Boston—one of the country's few interdisciplinary programs in the medico-legal field.

The text includes transcripts of the Nuremburg Code and of canons on investigation and research developed by several national and international bodies. It offers chapters by religious leaders on the theologic and moral aspects of human experimentation and clinical investigation. Areas covered include drug trials, scientific design, research technics, selection of research subjects, and problems of patient consent. A bibliography of over 400 references further enriches the text. Legal aspects of research and investigation are reviewed by experts.

The volume is chock-full of material that will provide fodder for speeches and conferences; and, more important, food for thought.

ULYSSES FRANK, M.D.

Atlas of Bone Tumors. By W. S. Gilmer, Jr., M.D.; G. B. Higley, Jr., M.D.; and W. E. Kilgore, M.D. St. Louis, 1963, Mosby. Pp. 165. ($27.50)

As an atlas, this is, of necessity, brief and incomplete. Yet it is an excellent reference for the student, as well as for the practitioner. It offers the significant biologic and diagnostic features of a series of lesions seen in a clinic and presented in an orderly fashion. It leaves to the student the pleasure of exploring the subject in depth.

The authors wisely develop a unified concept of the lesions described in the first eight chapters, which they feel is a "differential diagnostic unit;" that is, when one is suspected *all* are considered in the differential diagnosis. Diagrams bring out some of the common features of the first eight lesions as an effective means of presenting the differential diagnosis.

The term "osteitis fibrosa cystica" described by von Recklinghausen was, for many years, used to describe the skeletal lesions of hyperparathyroidism. It soon became apparent that several solitary bone lesions present the same picture as the focal lesions of hyperparathyroidism, localized "cystic" rarefactions caused by lesions formed of vascular fibrous tissue and hallmarked by multinucleated giant cells. Thus, this is then a useful generic designation to comprehend the lesions, considered in the first eight chapters, each a distinct entity but with a number of common denominators.

The remaining chapters cover the common bone tumors, including tumorlike lesions in groups in a logical fashion. A helpful chart illustrates the relative frequency of the lesions. The bibliography is fairly complete, well chosen, and current. The illustrations are excellent, particularly the photographs of the gross specimens.

It is a pity that an atlas of this type, which has so much value as a teaching aid, should be so expensive. It puts it out of reach of the very person (the student and interested colleague) for whom it was written.

WILLIAM G. BERNHARD, M.D.

Lysosomes. Edited by A. V. S. deReuck, M.Sc., and M. P. Cameron, M.A. Illus., Little, Brown & Co., 1963, Boston. Pp. 476. ($11.50)

This Ciba Foundation Symposium volume is an up-to-date, competent review of the lysosomes. First identified in rat liver cells in 1955, lysosomes are now known to occur in many—possibly in all—animal cells. The lysosomes, or "suicide bags," are subcellular particles filled with a powerful digestive juice capable of breaking down most of the constituents of living matter. As long as the lysosome membrane remains intact, digestion of the substrates on which these enzymes act is confined within the lysosome. But when the membrane is ruptured, the enzymes leak out and digestion takes place externally, often resulting in cell death. Some substances affect the stability of the lysosome membrane adversely, thereby increasing autolysis. Cortisone and hydrocortisone appear to have a stabilizing influence on the lysosome membrane. This property may account, at least partly, for the anti-inflammatory effects of these drugs.

Lysosome function and malfunction appear to be involved in such vital processes as the fertilization of the egg and the aging of cells and tissues. The death and dissolution of the cell following rupture of the lysosome membrane may play a part in the developmental processes of some animals and in a number of degenerative phenomena. This suggests that cell autolysis might be deliberately promoted or retarded for therapeutic purposes by substances affecting the stability of the lysosome membrane.

This book is the first comprehensive treatment of this new and important cellular organelle. Twenty-five authorities in electron microscopy, cell physiology, molecular pathology, and biochemical morphology have contributed text. This book may be unhesitatingly recommended as an introduction or review of what is known or believed about lysosomes.

HAROLD M. BATES, Ph.D.

Infectious Diseases of the Conjunctiva and Cornea. A Symposium of the New Orleans Academy of Ophthalmology. St. Louis, 1963, Mosby. Pp. 230. ($12.50)

This text represents one of the latest in what appears to be a new style in publishing: that is, a book based upon papers and round table discussions. Of all such anthologies that this reviewer has read, this is the least rewarding.

There is nothing unusual within its covers and nothing to be gained by the ophthalmologist who has an average library and who reads his journals fairly conscientiously. True, one is stimulated to do more bacteriology in one's office. The clinical descriptions, the diagnostic features, the therapeutic guides all sound a familiar note, however. The final chapter, a recounting of the roundtable discussions, is disappointing. There are, as an exception, several interesting remarks concerning the use of antibiotics, the use of drops or ointments locally, and a consideration of herpes simplex lesions.

This book suffers because of inexcusable errors in spelling and from insufficiently painstaking editorial work. Some of the chapters are repetitious, some laboriously written, some merely uninteresting. On the whole, this uneven book is one that the ophthalmologist really does not need.

S. JEROME GREENFIELD, M.D.

Human Aging. James E. Birren, Robert N. Butler, Samuel W. Greenhouse, Louis Sokoloff, and Marian R. Yarrow. Washington, D.C., 1963, U.S. Public Health Service. Pp. 328. ($3.00)

Forty-seven male volunteers were sampled from the *community* for a biologic and behavioral study. They were free of organic disease. Their median age was 71. Twenty-two investigators conducted exhaustive studies into the psychologic, psychiatric, physiologic, and sociologic functions. Parameters of cerebral blood flow, electro-encephalogram, cerebral oxygen consumption, psychomotor response, and auditory perception are recorded. Personality measurements including the Thematic Apperception, Rorschach, Homonyms test, and others are applied. The processes of arteriosclerosis and aging without arteriosclerosis are separated, and interesting conclusions are then drawn regarding the mechanism of memory loss and electrical activity of the brain. Statistical methodology is used. Sixteen neatly categorized chapters, replete with tables, indices, and appendices, make this volume well suited as a reference text as well.

RICHARD FADIL, M.D.

Preventive Medicine in World War II. Vol. VI. Communicable diseases. Malaria. By US Army. Medical Department. Washington, D.C., Office of the Surgeon-General, 1963. Pp. 642. ($6.25)

Although malaria is no longer a problem in the United States, it is still the most serious medical problem in the world from the standpoint of both morbidity and mortality. During World War II, the immense problem of malaria control was assigned to the Medical Department of the Army. The enormity of the task can be better understood if one realizes that our men were fighting in Africa, Italy, the Mediterranean Islands, the Middle East, the South Pacific, and the China-Burma-India Theater. Malaria is highly endemic in all of these areas. The control of this devastating disease during peacetime is a colossal undertaking. During war, the problem is compounded a thousand times.

This volume is not a textbook in the ordinary sense of the word. Rather, it is an absorbing history of the valiant efforts of the dedicated group of scientists to whom the task of malaria control was assigned. The contributions of this group and some of their achievements will have a far-reaching effect on the future world-wide control of this scourge. It is a fascinating book, distinctly worth reading. It leaves you with a feeling of pride in our Armed Services.

EDWARD HENDERSON, M.D.

Thoracic Surgery, Volume I. Edited by Frank B. Berry, M.D. Washington, D.C., 1963, Department of the Army. Pp. 394. ($4.25)

This is a compilation of experiences and observations during the last two World Wars with emphasis on the thoracic surgical problems. Part I deals mostly with the historical aspect of the problems together with discussion of the different types of chest wounds. Part II relates to the administrative problems, and Part III to the clinical aspect and general management of the patient with thoracic wounds. Authors include Dr. Dwight Harken, Dr. Michael De Bakey, and Dr. Brian Blades—just to name a few. I particularly like the part related to the thoracic exercises given to the patients at the 160th General Hospital, European Theatre of Operations. For those interested in thoracic surgery, perhaps this book will give a perspective in the historical development of our present knowledge in the treatment of thoracic injuries; but admittedly it has limited civilian application.

ADRIAN M. SABETY, M.D.

Handbook of Orthopedic Surgery. A. R. Shands, M.D.; R. B. Raney, M.D.; and H. R. Brashear, M.D. Sixth Edition. St. Louis, 1963, Mosby. Pp. 590 (with 220 illustrations). ($11.50)

This sixth edition brought up to date, presents the fundamental principles of orthopedic surgery in brief, readily available form. The most modern methods of diagnoses are described in a lucid, understandable fashion. Procedures in handling the simplest to the most complex fractures are more than adequately presented. Previous chapters on osteomyelitis and pyogenic arthritis have been combined because of the decreased incidence of these diseases. The result is a new chapter, brief and well written, which covers tuberculosis of bones and joints; and an added chapter on prostheses, amputations and braces.

To be noted in the preface are the names of distinguished surgeons who contributed to this work. Among the surgeons named, we find our own Dr. Toulick Nicola, as well as our New York neighbors, Dr. Philip D. Wilson and Dr. Leo Mayer. This important book should belong not only to every medical student, but should be on the medical library shelf of every up-to-date orthopedic surgeon.

HENRY DEVINCENTIS, M.D.

The Story of Blood. Kenneth Walker, M.A. New York, 1963, Philosophical Library. Pp. 213 ($6.00)

Written obviously for the layman, this provides an interesting tale concerning the vital organ known as blood. The author in providing a dramatic portrayal of its history reaches back to biblical references, ancient Greek and Roman history and mythology in addition to more recent scientific landmarks.

Chapters devoted to the anatomy, histology, physiology, and pathology of both the blood and cardiovascular systems are replete with both lay generalities and specific scientific references. The author is trapped by the conflict of how much the untrained can digest and how technical his references must remain to attract the knowledgable.

The chapters on hematologic diseases and the role of blood in immunologic functions present the greatest challenge. In both instances the problem of lay presentation is more than adequately met and affords the reader a clearer insight into an understanding of the daily press, radio, and television references.

LESTER M. GOLDMAN, M.D.

Handbook of Legal Medicine. Alan R. Moritz, M.D. and C. J. Stetler, LL.B. St. Louis, 1964, Mosby. Ed. 2. Pp. 240, with 16 illustrations. ($5.75)

In 1956, Dr. Moritz and the late Louis J. Reagan, M.D., LL.B jointly produced a compact little manual on legal medicine. In this current edition, the "legal" section is the work of C. J. Stetler, once counsel to the AMA. The first half of the book covers scientific medicolegal investigation—determining the cause of death, abortion, rape, blood tests, toxicology, and so on. The second half consists of 26 chapters, arranged alphabetically from artificial insemination to wrongful death. This section touchs on the legal responsibilities of physicians—operative consent, for example; malpractice; workmen's compensation laws; collection of fees and so on. The usefulness of the volume is enhanced by the inclusion of a glossary of legal terms. Because of the small compass of the book, there is, necessarily, some sacrifice of depth and exemplification.

HENRY A. DAVIDSON, M.D.

The Science Book of Modern Medicines. Donald G. Cooley. Hardback edition published by Franklin Watts, Inc., New York, 1963. ($4.95). Paperback, Pocket Books, 1964, New York. Pp. 228. ($0.50)

Through this book, the intelligent layman can get an exciting story of modern pharmaceuticals and human metabolism. The book covers major groups of drugs, and includes chapters on how the brain works and on how a new drug is thought of and developed. It is bound to give the reader an increasing respect for American pharmaceutical manufacturing.

VICTOR HUBERMAN, M.D.

Gastroenterology. Henry L. Bockus, M.D. Volume II, 2nd ed. Philadelphia, 1964, Saunders, Pp. 1241.

The tremendous progress made in gastroenterology is illustrated by the size of this second volume which deals basically with the small intestine and colon. This entailed, in the words of the author, a "rewriting rather than a simple revision." This was an absolute necessity, since the first edition was published in 1946.

The book is complete, up to date, and authoritative: a "must" for the gastroenterologist. No medical library should be without it. Any practitioner or student of medicine will find this a useful text. The illustration and x-ray reproductions are, for the most part, excellent. An occasional illustration, such as Fig 65-10, reproduced from a 1949 publication, serves no function. And surely the picture on the opposite page must have been included with a "tongue in cheek" attitude. Reference sources at the end of each chapter serve as baselines for further investigation.

The thoroughness of certain topics is open to question. For instance, there is only a brief paragraph on care of the ileostomy. Since this can be the most important aspect as to success or failure of total colectomy, more detail might have been given. This is information that is hard to come by and should be present in a book of this scope. A more fundamental fault lies in the "regional" representation of the authors. They are, by far, products of one "school." However, authorities in gastroenterology are located all over the country, and indeed the world. Their presence in this second edition would have given the book a sense of broadness.

Nonetheless, Bockus' *Gastroenterology* remains the definitive text to date in this rapidly growing field.

ALBERT N. SIEGEL, M.D.

Pediatric Therapy. Edited by H. C. Shirkey, M.D. With 72 contributors. St. Louis, 1964, Mosby. Pp. 1144 with 339 illustrations. ($16.50)

Dr. Shirkey once described himself as "a sick-baby doctor, not a well-baby doctor." This volume focusses largely, though not exclusively, on drug therapy. A 150-page section on pediatric surgery is a useful little monograph in itself. While it makes no pretense at being a guide to surgical craftsmanship, it does give the pediatrician a good orientation to surgical problems. Dr. Shirkey writes a thoughtful chapter on the use and abuse of placebos. Behavior disturbances and behavior problems are disposed of in 4 pages by a well-known pediatric psychiatrist. (He explains though that he is *not* writing a monograph on child psychiatry.) Appended to the text, on colored paper, is a 50-page table of dosages of commoner drugs. The book is well illustrated and covers almost every aspect of pediatric drug treatment in its 96 chapters.

RALPH N. SHAPIRO, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

MAY, 1965 • VOL. XXXVIII, NO. 5

TETRAETHYL PYROPHOSPHATE POISONING FOLLOWING AIRPLANE DUSTING

Both humans and cattle had respiratory distress following TEPP dusting of crops during a thermal inversion in the State of Washington. The several factors involved are discussed.

Despite reports of human poisoning caused by drifting pesticides, scientifically acceptable evidence has not been published showing that the drift of the newer organic phosphorous insecticides has produced poisoning clearly recognizable.

The purpose of this paper is to report two outbreaks of poisoning which occurred in the state of Washington in 1963 following the dusting of two different crops with tetraethyl pyrophosphate (TEPP).

In the first instance, two planes of a commercial pesticide applicator alternately dusted 46 acres of a vineyard of hops near Toppenish, Wash., with 1 per cent TEPP dust in a manner similar to that used for the past 16 years.

A thermal inversion existed during the application so that the dust settled into the 20-foot-high hop vines. Some drifted at least 700 feet beyond the vineyard over adjacent pastures, corn, and other crops, and over houses. The dust hung in the air and drifted slowly away from the swathes being laid down by the planes flying and loading alternately. It did not lift for almost two hours.

While it is not unusual for insecticides to be applied by aircraft during a thermal inversion, it is unusual for an inversion to cause such still air for so long. The cloud of dust over one house was so dense that it was not visible approximately 300 yards away. Except for the prolonged thermal inversion, this application appeared to differ in no way from those of past years.

Two Cattle Die

The owner of one farm noted that the cattle began to cough so soon after the dust cloud settled over the pasture that there was not time for the cattle to have eaten TEPP dust on the grass. Two heifers, found down within 50 feet of his home, started convulsing and died within the second hour after onset. Some degree of cyanosis was noted in the tongues of other cattle. The cattle were observed to stagger when they moved and several fell briefly to their knees. The signs were consistent with both topical and systemic poisoning with TEPP.

The 8-year-old son of the farmer, playing on the lawn, became so short of breath he went into the house and complained to his mother.

Subsequent investigation in the area brought to 15 the number of people known to have had shortness of breath or tightness in chest. All but three had completely recovered before leaving the area or before arrival at the hospital. The three with residual shortness of breath were hospitalized overnight. No treatment was required for any.

The sheriff's office was advised to have all persons showing any effects taken to the local hospital. A total of 41 persons were examined in the emergency room in addition to five who were examined in the field.

GRIFFITH E. QUINBY, M.D., MPH and GLENN M. DOORNINK, M.D., *Journal of the American Medical Association*, January 4, 1965.

Clinical Picture

The clinical pattern of this type of poisoning has been seen frequently in occupationally exposed persons such as flaggers, pilots, loaders, and other workers breathing TEPP dust.

The people in this outbreak described their experience as follows: the first complaint was usually the sweetish smell (ethyl esters) of the TEPP followed by dryness of the throat (talc) with a bad taste. Coughing usually followed promptly but was sometimes the presenting sign. After breathing the dust-laden air for about 30 minutes, victims noted tightness in the throat or chest followed by shortness of breath.

These symptoms are the result of bronchiolar constriction probably caused by the direct action on the muscles of the bronchioles of the inspired TEPP dust or vapors. The fact that none developed pinpoint pupils suggests that most of the TEPP vaporized from the dust before it could reach the eyes. No one complained of visual difficulties except for dust.

Blood cholinesterase activities among eight tested remained essentially within normal limits.

A similar, smaller outbreak involving man and cattle occurred about two weeks later four miles north of Wenatchee, Wash. An orchard was dusted with TEPP under almost static air conditions that allowed the dust to remain in the area about two hours. A man and his wife and their heifer developed respiratory symptoms. The animal "foamed at the mouth" and breathed with difficulty. The symptoms in the people disappeared in about two hours.

Although the cattle may have been more heavily exposed than the humans, available facts do not explain why cattle developed systemic poisoning and the humans and other animals did not.

A possible explanation is the relatively lower blood cholinesterase activities of cattle. Their red cell cholinesterase levels normally average only about two thirds of man, and cattle plasma activities are almost absent. These differences might influence the buffering action of the blood in combining with absorbed TEPP. Furthermore, cattle tend to be excited by airplane application and in their heavier breathing may have inspired relatively more TEPP than humans.

Several Factors

The absence of reports of outbreaks of this type of poisoning from drift of TEPP makes it unlikely that the cause has been any single factor. It appears more probable that an infrequent combination of several factors is required to trap dust-laden air in pockets for periods long enough to cause people in the area of drift to breathe enough TEPP to make them short of breath. These factors are (1) thermal inversion and consequent static air conditions for longer than an hour over a considerable area; (2) topography of land causing interference with even, slow movement of dust-laden air; and (3) tall-growing crops with dense foliage constituting walls of vegetation located on such terrain.

Increased alertness on the part of industry, agriculture agencies, departments of public health, and the medical profession may be all that is required to prevent frequent or more serious recurrence of such episodes. Whenever clouds of TEPP dust tend to concentrate or remain static longer than usual, people should be urged to remove themselves and their cattle until the cloud has disappeared.

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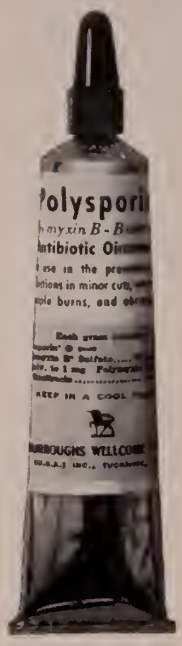
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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montre June 14–19, 1964.

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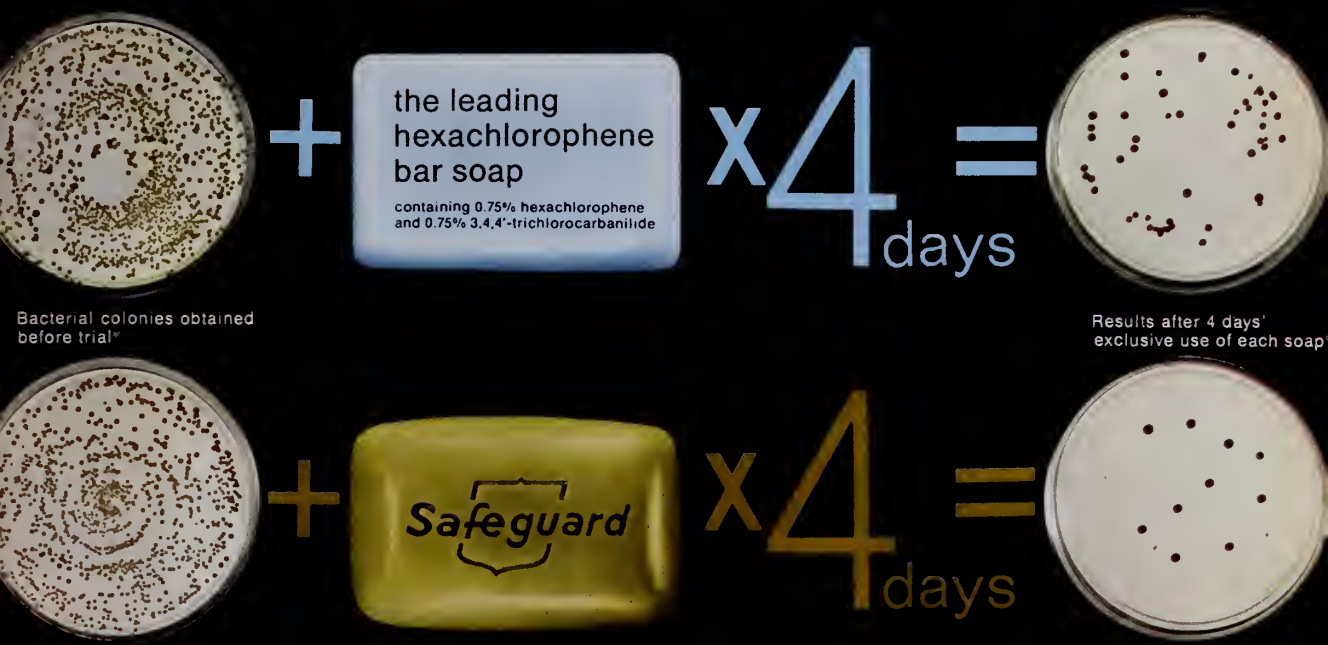
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SURGERY AND GENERAL PRACTICE—

Ralph N. Lee, M.D., Veterans Administration Hospital, Fort Howard, Maryland. Howard University Medical School 1960. General surgical residency. Available July 1965.

NEUROSURGERY (partnership or solo)—

Mario Ludmer, M.D., 256 Highland Avenue, Pittsburgh, Pa. 15229. University of Buenos Aires School of Medicine 1956. Board eligible. Available immediately.

GENERAL PRACTICE—

Edward G. Krug, M.D., 142 Merson Drive, Buchanan, Michigan 49107. Wayne State University 1958. Available immediately.

PATHOLOGIST—

James Ernest Haines, M.D., Worcester Foundation for Experimental Biology, 222 Maple Avenue, Shrewsbury, Massachusetts. Stanford University Medical School 1955. Board certified in Anatomical Pathology. Board eligible in Clinical Pathology. Available October 1966.

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References: 1. Handelman, Cathryn C.: Early management of acne, *Pediat. Clin. North America* 8:265, Feb., 1961. **2.** McLean, I. E. D.; Graham, K. T., and East, M. O.: The treatment of acne; a trial of "pHisoHex," *Practitioner* 189: 82, July, 1962. **3.** Hodges, F. T.: Therapeutic applications of an antiseptic detergent, *GP* 14:86, Nov., 1956. **4.** Wexler, Louis: Treatment of acne vulgaris, *Clin. Med.* 70:404, Feb., 1963.

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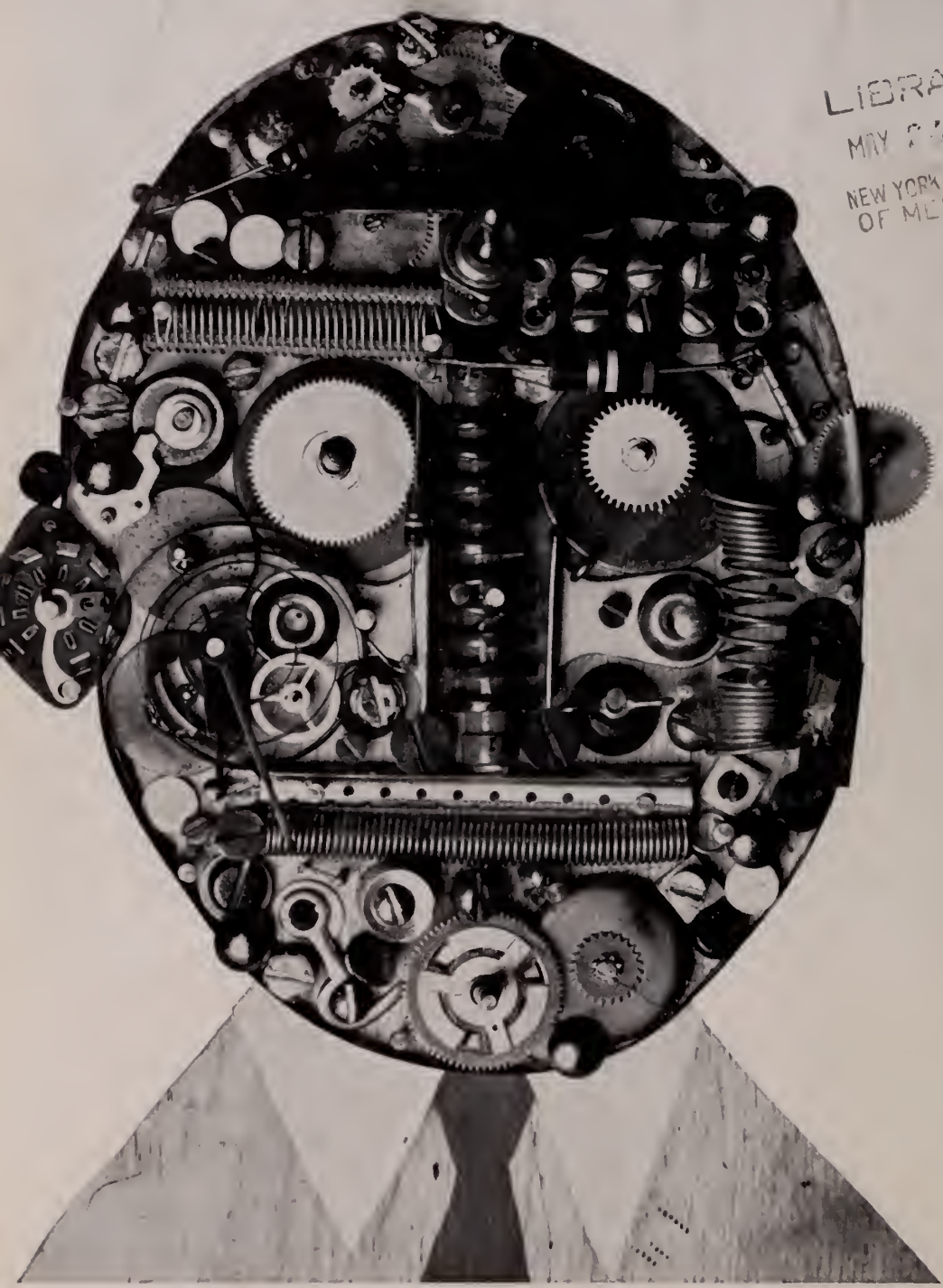
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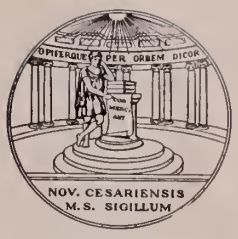
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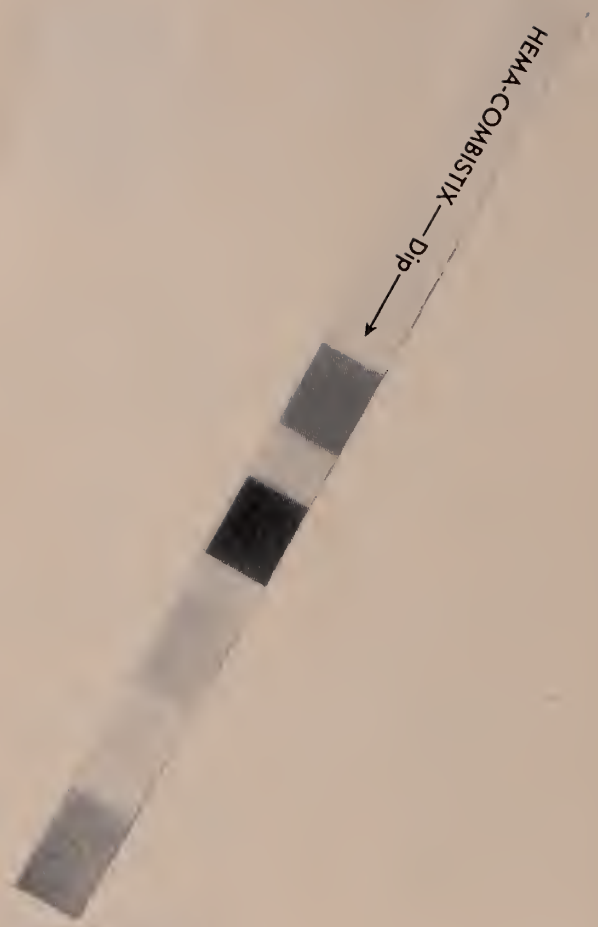
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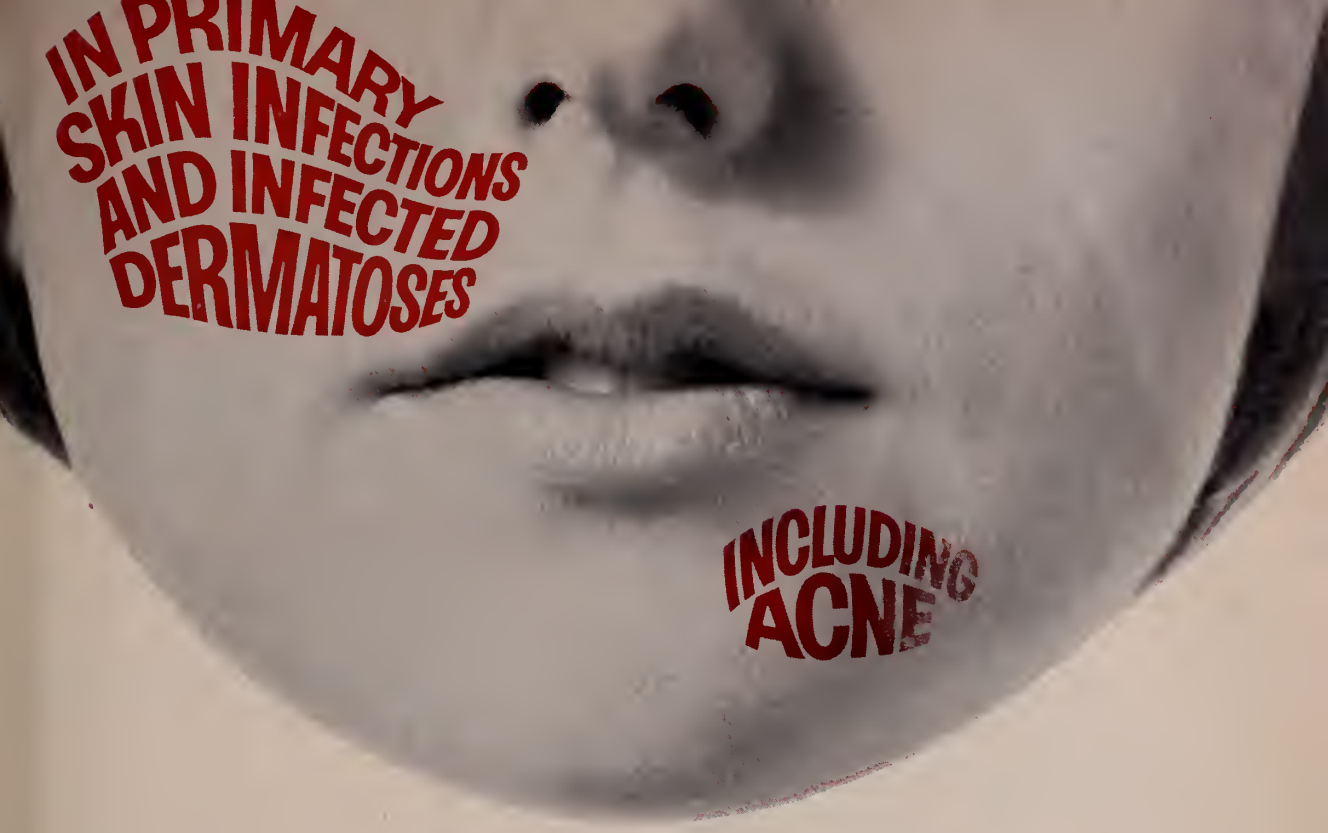
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(1) *Frykman, H.M.: Minn. Med., Vol. 38, Jan.* (2) *Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April* (3) *McGivney, J.: Texas State Jour. of Med., Vol. Jan. 1955.* (4) *Stern, F. H.: Jour. of The Amer. Vol. 11, No. 3, Mar. 1963.* (5) *Weekes, D. J.: Jour. of Med., Vol. 58, No. 16, Aug. 1958.* (6) *Jour. of Oral Surg., Anes. & Hosp. Dental Serv. July 1961.* (7) *Weekes, D. J.: E.E.N.T. Digest, No. 12, Dec. 1963.*

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New broad-spectrum penicillin but without broad-spectrum toxicity[1-10]

no blood dyscrasias
no photosensitivity
no severe gastric disturbances
no pigmentation of teeth
no kidney damage
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PENBRITIN (ampicillin) brings the traditional penicillin advantages to areas of treatment formerly dominated by the tetracyclines and chloramphenicol – urinary and gastrointestinal infections, as well as respiratory infections. But PENBRITIN (ampicillin) *does not cause the toxic disorders* associated with other broad-spectrum antibiotics.[1-10] And highly important: PENBRITIN (ampicillin) *kills* bacteria instead of merely suppressing them.

Usual dosage: Adults – 250 mg. every six hours in respiratory infections; 500 mg. every six hours in urinary and gastrointestinal infections (higher doses may be needed in severe infections). Children – (under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms.

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

Supplied: No. 606 – Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

References: 1. Editorial. Brit. M. J. *ii*:223 (July 22) 1961. 2. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 3. Stewart, G. T., *et al.:* Brit. M. J. *ii*:200 (July 22) 1961. 4. Brown, D. M., and Acred, P.: Brit. M. J. *ii*:197 (July 22) 1961. 5. Batchelor, F. R., *et al.:* Nature *183*:257, 1959. 6. Knudsen, E. T., *et al.:* Brit. M. J. *ii*:198 (July 22) 1961. 7. Doyle, F. P., *et al.:* Nature *191*:1091 (Sept. 9) 1961. 8. Acred, P., *et al.:* Brit. J. Pharmacol. *18*:356, 1962. 9. Harrison, P. M., and Stewart, G. T.: Brit. J. Pharmacol. *17*:420, 1961. 10. Editorial. Lancet *ii*:723 (Oct. 5) 1963.

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The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Psoriatic arthritis responds in the same way as rheumatoid arthritis but the skin lesions are usually not affected either favorably or adversely by treatment.

Precautions
Before prescribing, the physician should obtain a complete history and perform a complete physical and laboratory examination, including a blood count.

The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools.

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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IMPORTANT FACTS

about

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(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

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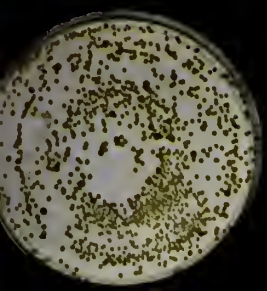
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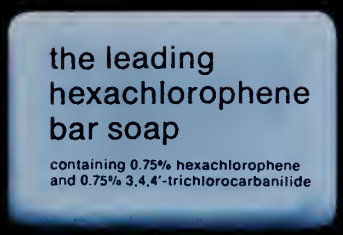
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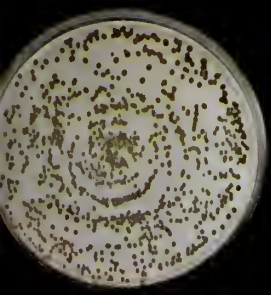


x 4 days =



Bacterial colonies obtained before trial*

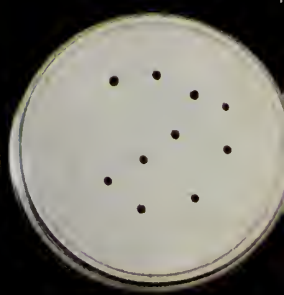
Results after 4 days' exclusive use of each soap



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new Safeguard® antibacterial bar soap keeps bacterial skin count lower than hexachlorophene bar soap



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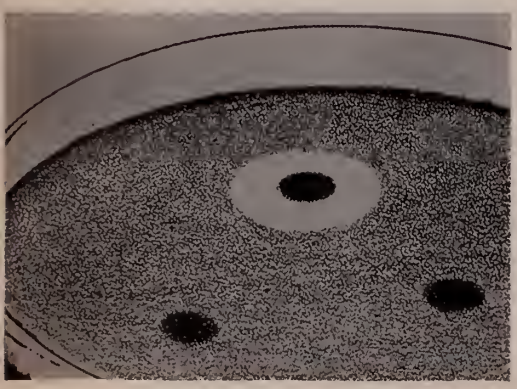
Desbutal 10—10 mg. Methamphetamine, 60 mg. Pentobarbital.
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Before they can develop into pyelonephritis, pyonephrosis or some other potentially life-threatening urinary condition. With NegGram, a specific urinary antibacterial. Clinical reports and extensive patient use show that in adults two 500 mg. NegGram Caplets® orally four times a day will control most urinary infections. Quickly...effectively...with minimal side effects. **Gram-negative urinary infection—cystitis, pyelitis, pyelonephritis, prostatitis, urethritis? Start first with NegGram ..."a good 'starting' drug."**[1] NegGram "...treatment may be first choice in potentially curable gram negative bacterial urinary infections."[2]

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

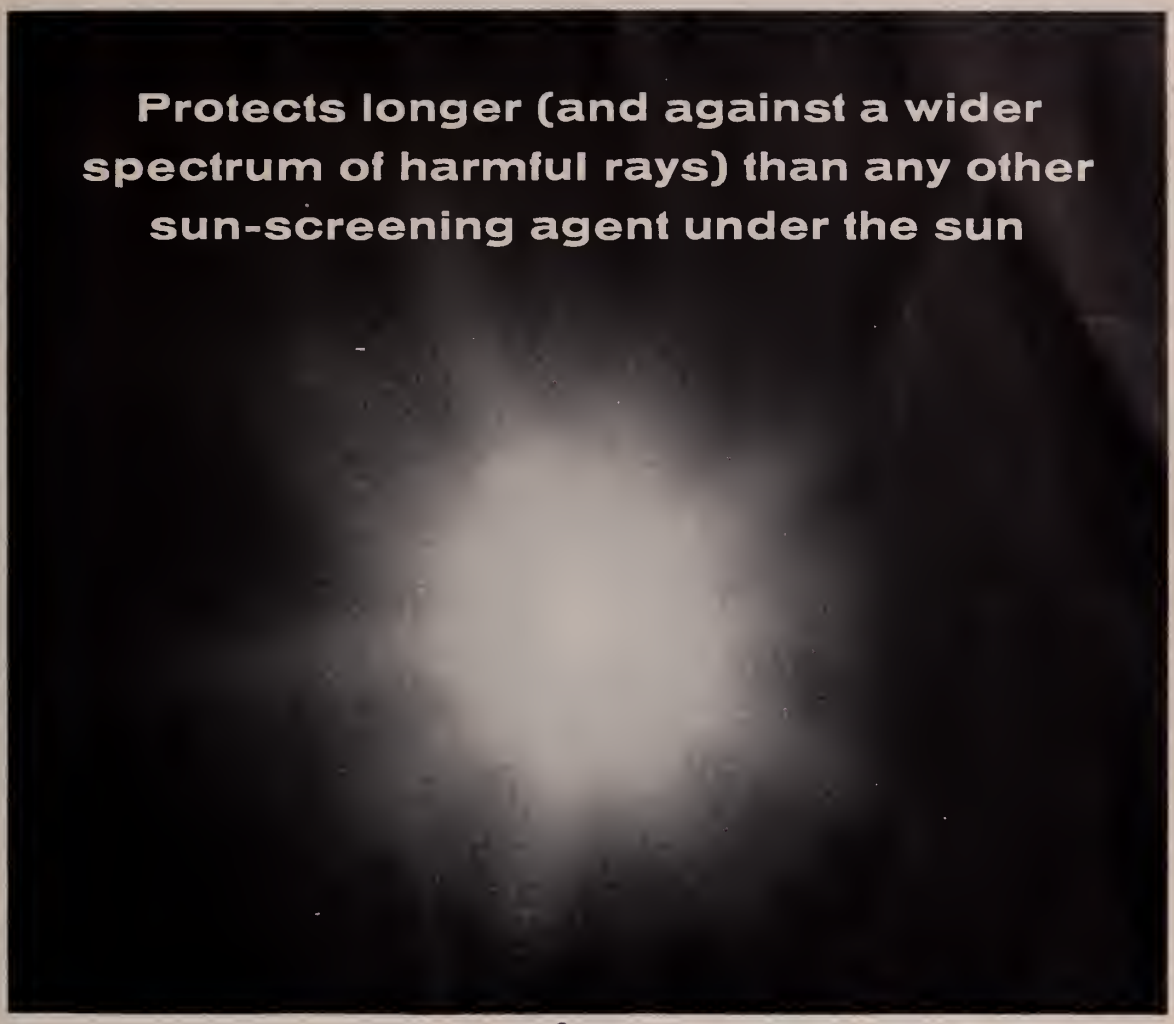
Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1,000. **250 mg. for children,** available in bottles of 56 and 1,000.

References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).











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Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Average Dosage: One tablet daily with breakfast.
Availability: Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal June 14–19, 1964.

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EDITORIALS

Meet The Colonel



The man at the helm for the coming year is John Joseph Bedrick. Born under the sign of Taurus and in the administration of William Howard Taft, he earned his baccalaureate degree at Columbia and his M.D. at that University's College of Physicians and Surgeons. He served a six-months' internship at the Norwalk (Connecticut) Hospital. Dr. Bedrick accepted a surgical internship at the New York City Hospital, Welfare Island, New York. After that he became an anesthesiologic resident there, and then took residencies and graduate training in surgery and surgical pathology.

With all that under his belt, he came to Bayonne to enter private practice just before they dropped the first bomb on Pearl Harbor. Dr. Bedrick, without waiting for that event, went on active military service, and spent the next five years in uniform, most of it at foreign installations. He never severed his army affiliations, however, and is now a colonel in the Army Reserve and commanding officer of the 322d General Hospital located in Newark.

On being mustered out of active duty, he opened his office in Bayonne and has served the people of that area for these 20 years. Dr. Bedrick is a surgeon, an attending in that field at the Bayonne Hospital. He has been president of the Bayonne Medical Society and the Hudson County Medical Society. He is an F.I.C.S. and has long served as a Trustee of The Medical Society of New Jersey, and as an assistant medical examiner for his County. He brings to our presidential chair several decades of experience in top level administrative organizational leadership as well as an intimate knowledge of the satisfactions and problems of private medical practice.

Hitting The Medicine Bottle

Man is the only medicine-nipping creature on earth. When a lower animal gulps medicine, it is only because some man has forced it on him. However, whether the credit goes to oral eroticism or TV commercial artistry, the fact is that many humans just love to take medicines. In Britain, for example, the first effort to discourage excessive medication was to impose a one-shilling charge per bottle. In spite of this, there was a continued demand on panel doctors for more prescriptions; not only that, but patients bought additional medicines from grocers and chemists. (In the USA the chemists are called pharmacists.) The passion for medicine-nipping seems, in a sense, to be a hereditary disease. At least, it is now said in the United Kingdom that hypochondriacal

patients are passing along this passion to their offspring. A team of physicians sent out by the British Medical Association has reported that, in their survey, 60 per cent of the interviewees had taken medicine on their own, without consulting a physician. Among children under the age of four, some 70 per cent had dutifully guzzled medication given to them by anxious parents without medical sanction. About 20 per cent of children with normal bowel patterns were fed laxatives on the theory that the digestive system cannot function properly without this nudging.

Pain-killers were the major unprescribed medication; some 40 per cent of all adult interviewees had taken anodynes without prescription. Even more astonishing: 20 per cent of children had been given pain-killing drugs based on advertising claims and without medical consultation.

When Britain's National Health Service was launched in 1949, there was an estimate that drug costs would amount to $490 million and might—just possibly might—reach the half billion dollar mark. In 1960, the reported figure was 2½ billion dollars.

In the USA we hear many complaints about the high cost of medication—and some envy of the Briton who can get a $5 bottle of capsules for only a shilling. (The Government pays the deficit.) One is remined of the cartoon showing a retail pharmacist talking to a customer. "You want it at cost?", he asks. "Well," continues the druggist, "the research cost 3 million dollars and. . . ."

Even our substantially priced drugs do not curb the compulsion to take medicines. The commercials sound so convincing over television that it seems almost un-American not to try the liquid that will pep up tired blood, the capsule that has seven vitamins built into it, the antacid that pours a fire-extingnishing foam over the flames that come out from the televised stomach, the ointment that will rub pain out, and all the other alembics that promise us happiness, charm, sex appeal, and relaxation, if only we will tip the advertised medicine bottle.

Mrs. Lewis C. Fritts



The incoming president of our Woman's Auxiliary is one of the few to have been wives of ex-presidents of The Medical Society of New Jersey. Marion Snyder Fritts was married to Dr. Lewis Fritts in 1937 in the famous old Trinity Church in Princeton. She is of the fourth generation in her mother's family to have been married in that historic shrine. Mrs. Fritts has three children: Anne Louise, Cornelia Benham, and James Lloyd Fritts. Our Society suffered an irreparable loss on April 6, 1961 when Dr. Fritts was taken from us. For several years, Marion Fritts was president of the Woman's Auxiliary Board of the Somerset Hospital, and is now on its Executive Board. She is also the Somerset County Coordinator for the State Committee on the Volunteer Friendly Visitors' Program and vice-president of the Bound Brook Garden Club.

Mrs. Fritts served in most offices in the Somerset County Woman's Auxiliary as well as in the Woman's Auxiliary to The Medical Society of New Jersey.

ORIGINAL ARTICLES

Our President here issues a call that would continue The Medical Society of New Jersey as a truly "great society."

Maintaining A Great Society*

John J. Bedrick, M.D./Bayonne

Frankly, I am intimidated and overawed by the honor and responsibilities with which today you invest me as the 173rd president of The Medical Society of New Jersey. I think I would not find the courage to assume the burdens and dignity of this high office were I not fortified by the consciousness that by your selection of me you have indicated that you discern in me the necessary qualities of mind and spirit. I thank you for your confidence in me, and I assure you that it shall be my constant endeavor to prove myself worthy of both the presidency itself and of your trust in me.

In a day when the term is casually used we can, in the light of history, unequivocally declare that The Medical Society of New Jersey is truly "a great Society." It is a great Society because it has had as its members through the years men and women of character and worth who imparted greatness to it. It is a great Society also because only a great Society would have the essential vigor to withstand the ravages of change and the vicissitudes of two hundred years.

Ours is the responsibility collectively, in the face of present changes and vicissitudes, by concerted and generous effort to preserve and enlarge the greatness of The Medical Society of New Jersey. Ours is the responsibility individually to develop and give of our personal and professional best, that by cultivating greatness in ourselves we may, like our predecessors, impart greatness to the Society which we constitute. There is no other way.

Basically there exists for each of us only one compelling reason for belonging to The Medical Society of New Jersey, and that is, by association with others of like humanitarian inspiration and dedication, to make ourselves as members of this Society "most capable of serving mankind." That is the climactic purpose of our organization, as set forth in Article II of its Constitution. To qualify as members, we must want to serve mankind, and to serve as well as we can. Thus it has been for two hundred years, and thus, please God, it will always be.

It is characteristic of all professions to have as their primary concern the service of mankind. He who seeks only to serve self does not belong in the ranks of a profession. Sacrificial idealism is fundamental for genuine professional success. The representative professional person grows rich by giving, for in the effort to enlarge his capacity for giving he increases his own capabilities and powers. Thus he proves

* Inaugural address, delivered at the annual meeting in Atlantic City, May 18, 1965, by Dr. Bedrick on the occasion of his installation as President of The Medical Society of New Jersey.

the soundness of the axiom that declares "No man can become great until he finds some one or some thing to serve that is more important to him than himself." We of medicine serve medicine only as a means—as the means by which we can best serve our fellowmen.

Woodrow Wilson, in his Swarthmore Address, speaks sagely in this connection. What he says concerning the identifying marks of a true college graduate applies with even greater force to the members of any learned profession, since the member of a learned profession is a college graduate who has embraced postgraduate studies and disciplines the better to carry on the humanitarian work to which he has committed himself.

So Woodrow Wilson speaks to you and me and our colleagues of all the professions when he declares: "What a man ought never to forget with regard to a college is that it is a nursery of principle and of honor . . . I cannot admit that a man establishes his right to call himself a college graduate by showing me his diploma. The only way he can prove it is by showing that his eyes are lifted to some horizon which other men less instructed than he have not been privileged to see. Unless he carries freight of the spirit, he has not been bred where spirits are bred."

He goes on to say: "We die but once, and we die without distinction if we are not willing to die the death of sacrifice. Do you covet honor? You will never get it by serving yourself. Do you covet distinction? You will get it only as the servant of mankind."

It seems to me that there is no very great difference between the ideals of the college graduate as Wilson proclaims them, and the ideals of all who qualify as worthy members of the profession of medicine.

For two hundred years now The Medical Society of New Jersey has enjoyed honor and distinction because of those representative members who have, with mind and heart, served their fellowmen. It is our challenge to live up to their example, and through sacrifice and service to prove ourselves—as their descendants and proper successors—the contemporary preservers of the great Society which they created and gave to our keeping.

The service of mankind as rendered by men and women of educational and professional attainment is not, and should not be, a blind commitment to do whatever our contemporaries demand of them. All genuine and constructive service provides only benefits that are consonant with the true good of those who are served. One does not well serve his fellowmen who encourages them in all their impulses and desires without regard to the potential for good or evil of those impulses and desires. Nor does one serve well, on the other hand, by automatically denying assistance to his fellowmen simply because what they seek is something which has not been sought before.

The question which the true statesman, physician, lay leader, teacher, or parent must ask in relation to each new purpose or position is "Will this be conducive to the individual and the general good?" Only when the answer is "yes" does the support of the end sought rightly fall under the heading of "service to mankind."

Of course, in the everyday practice of medicine we all know this. One doesn't knowingly embrace a limited good that is inevitably yoked to a larger evil. One doesn't give in to the pleas of the patient or his family unless the action sought is compatible with the patient's total welfare. The rightness of this principle has found reflection in statutes of law and canons of ethics, until now conformity with that principle is not merely a matter of rational conviction for the practitioner of medicine, but of legal or ethical obligation.

I have said that the standard of judgment to be brought to bear by those who serve mankind is the total welfare or good of the patient. This fact has led medicine into close affiliation, in the interest of the patient's welfare as a whole man, with the ministers of religion. We recognize that the total health of the patient embraces physical and moral elements. We recognize, likewise, that that

total health involves his social well-being, also. In consequence, in a rapidly changing world, as servants of our fellowmen we have been and are involved in the efforts to achieve enduringly sound and satisfactory solutions to questions of a socio-economic nature.

Our concern and our obligations as members of the profession of medicine extend to include not only the total health of each of our patients—in its physical, moral, and social aspects—but even the total health of the life of our American society. It would be a barren victory to win for the individual a harmony of physical, moral, and social health, if, in his added years and with his added vigors, he were doomed to drag out his life bereft of freedom of action and bereft of the right and responsibility to guide his own life and to fashion his own success or failure.

These are times of sweeping change. If we are to best serve mankind—as we have pledged to do—it must be our work to see to it, as far as in our power lies, that such changes as come about in American medicine and American life are conducive to an increase in the general good and are consonant with the total health and character of the individual citizen.

Medicine has always been receptive to, and supportive of, constructive change. Through the years it has unhesitantly abandoned concepts and practices which new discoveries proved to be unsound or inefficient. The science of medicine has grown stupendously in consequence of this willingness to strive, to seek, and to find.

In consequence, too, with each passing decade the members of the medical profession have been able to better serve mankind not by changing for the sake of change, of course, but by intelligently adapting to new and demonstrated truths, and by intelligently abandoning concepts and practices which greater knowledge has demonstrated as no longer intelligently tenable.

Thus, we must proceed today . . . open-mindedly disposed to weigh and consider all proposals for change, but staunchly determined to accept and support only those changes which are constructive and wholesome, only those changes which will really improve the character and condition of our fellowmen, individually and collectively.

This is no new policy for The Medical Society of New Jersey. It resulted in the Society's establishment in 1942 of the Medical-Surgical Plan of New Jersey (New Jersey Blue Shield Plan), to make available, under the insurance principle, comprehensive service benefits for New Jersey subscribers of specified income categories. The wholesomeness of this innovation has been demonstrated by the unprecedented growth of the MSP coverage, until now—as one of the best insurance coverages of its kind in the United States—it affords a broad and encompassing protection, at consistently low rates, for more than two and a half million New Jersey beneficiaries.

This policy has led to the Society's cooperation in supporting the complementary comprehensive service coverage of the Hospital Service Plan of New Jersey (New Jersey Blue Cross Plan), which likewise has had a distinguished success.

This was the policy underlying the endorsement—on an experimental basis for one year—of the recently inaugurated AID (Approved by Individual Diagnosis) Program. This program, the first of its kind in the nation, bases the durational limits of utilization of the insurance coverage upon the diagnosed condition of the patient as supplied by his attending physician. It is hoped that the AID Program will effectively equate the length of hospital stay with the patient's authenticated need, and will thus protect the financial structure of New Jersey Blue Cross and assure the continued availability to the people of New Jersey of this popular and invaluable voluntary comprehensive hospital service insurance coverage.

By instances and actions such as these, The Medical Society of New Jersey has evaluated and adapted constructively to changing times

and circumstances, in a way at once protective of the freedom and independence of the individual—whether physician or patient—and genuinely advantageous to the general good. This we must painstakingly continue to do. Our responsibility is vastly greater today than was the responsibility of our predecessors of other generations. But our knowledge is vastly greater, and the possibilities of constructive service are rich beyond anything the physicians of other ages ever dreamed of.

In this, the two hundredth year of our Society's existence, let us rededicate ourselves to the determination to make the most of our true best for the genuine good of our fellowmen, so that they may live out their lives in a state of total, balanced health and wholesome well-being, that will be a source of dignified satisfaction to them as rational agents and a source of strength and greatness to our country.

945 Avenue C

New Interagency Council on Smoking

Announcement is made of a new Council on Smoking: an organization of health, education, and youth-interest groups, concerned with cigaret smoking and its effects on human health. Council membership now consists of 16 professional, private, voluntary, and governmental organizations. It provides a cooperative and independent force to inform the public regarding the effects of tobacco use, especially cigaret smoking.

The Council observed the first anniversary of the Report of the Advisory Committee to the Surgeon General, *Smoking and Health*. So far 350,000 copies of the report have been distributed, including those mailed to practicing physicians.

In an address to the Council, the Surgeon General, Dr. Luther L. Terry, reported that a survey indicates at least 18 million Americans have quit smoking cigarets and, in his words, "have been off long enough for most of them to stay off." In addition he said that millions of adult cigaret smokers are ready to be convinced that the time has come to change their smoking habits; and added, "Therefore, the opportunity to convince them in 1965 and the years ahead is great."

Other reports at the Council meeting indicated an impressive growth of state interagency councils throughout the nation, some 29 states having reported formation of these cooperative organizations patterned after the National Council. According to Dr. Malcolm H. Merrill, California Director of Public Health, 16 of the state interagency councils are chaired by physicians, many of whom are in private practice. In California, Dr. Merrill said, the state Medical Association is actively participating in the Interagency Council and plans to recruit 1,000 physicians as a committee of speakers and educators to combat the health hazards of smoking. In addition to their leadership, these physicians will help to organize programs to assist smokers to give up the habit.

Emerson Foote, new Chairman of the National Interagency Council on Smoking and Health, reported on reliable estimates as to the total mortality attributable to smoking. He stated ". . . it may be said with sureness that cigarette smoking is today responsible for *at least* 125,000 deaths each year in the United States. Cigarette smoking *may* be responsible for as many as 300,000 deaths per year in this country. Either figure represents a national catastrophe."

Senator Maurine B. Neuberger, a guest speaker at the Council meeting, referred to a survey made by the Public Health Service which measured public attitudes about smoking. She said an overwhelming majority of those polled are strongly in favor of certain regulations in the labeling and advertising of cigarettes.

It is apparent that a beginning has been made in reducing the health hazards of cigarettes. It appears that the national and state interagency councils will play useful roles in this program. Further information about the group is available from the Medical Tobacco Bulletin, Room 712, at 1790 Broadway, New York, N.Y. 10019.

For the first time in American literature, there is here presented a clinical and anatomic involvement of the posterior pituitary by a chronic myelogenous leukemia.

Diabetes Insipidus Complicating Chronic Myelogenous Leukemia*

Milton E. Landman, M.D./Bloomfield
Harry H. Stumpf, M.D./Montclair

Among the uncommon complications of the leukemias is diabetes insipidus.[1] A review of the world literature reveals only eleven reported cases. Three of these[2,3,4] were acute or chronic lymphatic leukemia, three monocytic or acute paramyeloblastic (Naegeli),[5,6] four acute myeloid,[1,7,8,9] and one chronic myeloid type.[10] The present report is apparently the first in the American literature describing both clinical and anatomic involvement of the posterior lobe of the pituitary gland by chronic myelogenous leukemia.

A 38-year old woman was seen for purpura of the lower extremities on November 28, 1956. No other abnormal bleeding or other symptoms were present. Five years previously, she had received deep x-ray therapy to the flanks for hypertension and obesity followed by a seventy-five pound weight loss. Other significant illnesses or operations were denied. Positive physical findings were a blood pressure of 182/88 and several small areas of purpura on the lower extremities. The spleen and liver could not be palpated. The white blood count on admission was 150,000 with a differential of 1 percent myeloblasts, 2 per cent promyelocytes, 7 per cent myelocytes, 11 per cent metamyelocytes, 22 per cent immature neutrophiles, 46 per cent mature neutrophiles, 4 per cent lymphocytes, 5 per cent monocytes, 1 per cent eosinophiles, 1 per cent basophiles. Red blood cells numbered 4,000,000, hemoglobin was 12 grams, bleeding time 30 seconds, coagulation time 5 minutes, and Rumpel-Leede Sign negative.

The patient's first admission to the Mountainside Hospital was on December 5, 1956. Bone marrow examination showed chronic myelogenous leukemia (Figures 1 and 2), and the patient was discharged on busulfan,† 4 mgm daily. Platelet counts on two occasions were 142,000 and 286,000. Serial white blood

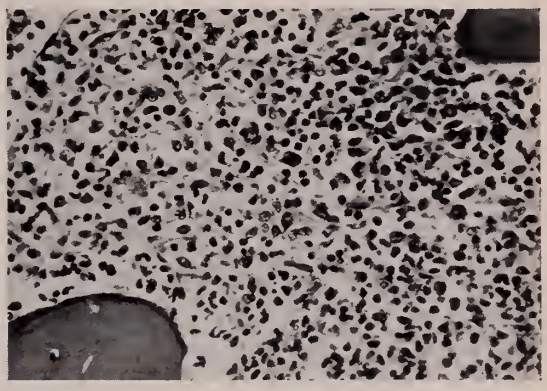


FIGURE 1

Leukemic infiltrate, Sternal marrow biopsy, Dec. 1956. Many abnormal granulocyte precursors including large, monocytoid cells. Hematoxylin and eosin stain, X 550.

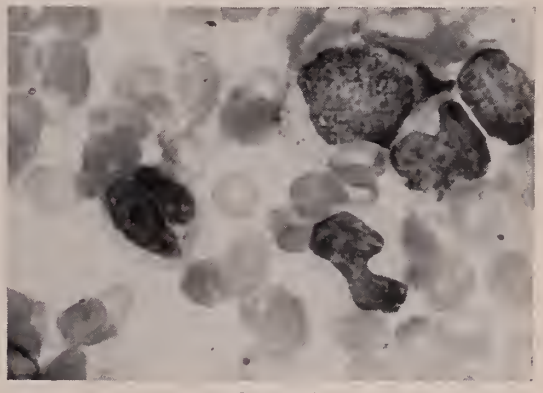


FIGURE 2

Smear of peripheral blood, December 1956, showing details of abnormal monocytoid cells. Large cell, upper right, resembles myelocyte. Wright's stain, oil immersion, approx. X 2200.

* From the Departments of Medicine and Laboratories, The Mountainside Hospital, Montclair, New Jersey.

†The busulfan was given under the Burroughs Wellcome tradename of Myleran®.

cell counts showed a gradual return of the granulocytic elements to normal. Busulfant was reduced and then discontinued in July 1957 when a few ecchymoses were noted. On April 25, 1958 bone marrow examination revealed only a mild shift to the left. She continued in complete remission without further therapy until September, 1958 when ecchymoses were again noted and the platelet count was found to be 30,000.

On October 7, 1958 she was readmitted to the Mountainside Hospital. The only significant physical finding consisted of multiple purpuric areas. Again spleen, liver, or lymph nodes could not be palpated. A total leukocyte count of 60,000 included many young forms of the myelocytic series. Multiple blood transfusions of fresh blood by plastic bag technic were given. Busulfant 2 mg. daily and prednisone 30 mg. daily were instituted. Two weeks later, dysphagia appeared. An esophogram revealed obstructive infiltration in the mid-portion. A total of 200 roentgen units were delivered to the esophagus in four divided doses with complete resolution of the process both clinically and by x-ray. The patient was discharged on November 26 on Myleran® 2 mg. daily and prednisone 30 mg. daily. The white blood count was 6,800 with frequent young forms, and the platelet count was 50,000.

The third admission was on January 3, 1959 following a fall with abrasions of the face and body. Decreased to absent deep tendon reflexes and reduced vibratory and position sense were noted as well as hypesthesia of all four extremities. The total leukocyte count was 32,000 with many myelocytes, premyelocytes, and a few blast forms. The red blood cell count was 3,500,000 with hemoglobin 11 grams and platelets 54,000. The impression of a neurologist was that this represented leukemic involvement of dorsal roots. The busulfan† was increased to 4 mg. daily and prednisone to 50 mg., and the patient was discharged on January 12, 1959.

She was readmitted for the fourth time on June 13, 1959. She had remained substantially unchanged until one week earlier, when she had noted polydipsia and polyuria progressing to almost continual ingestion of fluid and urination. This was accompanied by weakness and fever. The 24-hour intake of fluid was 5,200 cubic centimeters. The 24-hour output was 5,600 cubic centimeters. A urine concentration test indicated a maximum specific gravity of 1.003. At this time a hypertonic saline test was contemplated, but the patient went into clinical shock with rapid and thready pulse and blood pressure 40/0. Aqueous Vasopressin® 0.25 cc. every 4 hours intramuscularly was instituted as well as an intravenous infusion of Solucortef†† in normal saline with almost immediate return of the blood pressure to normal levels. The polyuria and polydipsia were completely controlled on the aqueous Vasopressin,® which after 24 hours was changed to vasopressin tannate†† in oil, 5 units daily. Despite negative skull films radiation was delivered to the sella turcica. For the first time the spleen was found to be enlarged on this admission, and it was also irradiated. The patient was discharged on July 3, 1959 on 5 units daily of vasopressin tannate in oil†† with continued good control of polyuria and polydipsia.

The fifth and last admission was on July 9, 1959. Her white blood cell count had risen to 97,000 with many myeloblasts. A necrotizing stomatitis had developed making it impossible for the patient to eat. Candida albicans and E. coli were grown out on culture. Despite therapy with chloramphenicol,†† Nystatin,†† and prednisone the patient pursued a febrile, rapid downhill course, and died in coma on July 25, 1962. Clinical diagnosis was chronic myelogenous leukemia with terminal myeloblastic crisis, leukemic esophageal and posterior pituitary lobe infiltration, and necrotizing stomatitis.

Autopsy was done two hours postmortem. The body was mildly obese with slight hirsutism and numerous, small, recent hemorrhages in the skin everywhere but particularly over the breasts and anterior abdomen. Moderate leg edema was present. Many grey-white plaques were seen on the diaphragmatic pleura and in the visceral and parietal pericardium. Gross signs of leukemic infiltration were also noted in the myocardium, liver, spleen, kidneys, gastric mucosa, bone marrow, and lymph nodes. The liver and spleen were markedly enlarged (3060 and 820 Grams respectively), and in the spleen were many old and recent large infarcts. Several large iliac vein tributaries were filled with granular, rubbery, grey-white thrombus material made up largely of leukemic cells. Similar small emboli were found in small pulmonary artery branches bilaterally. In all chambers of the heart were small, organizing grey-white mural thrombi. Both adrenal glands were hemorrhagic; the right containing a



FIGURE 3

Pituitary gland, sagittal section, showing marked atrophy and fibrosis of posterior lobe, right, with heavy leukemic infiltration, dark margin, extreme right. Hematoxylin and eosin stain, X 16.



FIGURE 4

Higher power magnification of remnants of posterior lobe, lower left, showing fibrosis with a few macrophages and intense leukemic infiltrate also involving gland capsule on the right. Hematoxylin and eosin stain, X 220.

††Solucortef® is the Upjohn tradename for succinate sodium ester of hydro-cortisone. The brand of vasopressin used was the Parke-Davis brand tradenamed Pitressin®. We used the Parke-Davis brand of chloramphenicol, which is tradenamed Chloromycetin® and the Squibb brand of nystatin, which has the proprietary name of Mycostatin®.

hematoma, the left almost completely obliterated by blood that had dissected up behind the pancreas and downward lateral to the left kidney. Recently formed thrombi partly occluded both adrenal veins. The vertebral bone marrow was dull grey-green. The brain was unremarkable but the pituitary gland seemed to section with increased resistance, particularly the posterior lobe.

Microscopically there was generalized infiltration of all organs by abnormal monocytoid cells, myelocytes, and numerous blasts, the former similar to those described in the biopsy taken in December of 1956 (Figure 1 and 2). Most severely involved were the heart, liver, spleen, bone marrow, kidneys, pituitary gland, and lymph nodes. Lighter infiltration was seen in the skin, lungs, oral, esophageal and gastric mucosa and in the uterus and adrenal glands.

Of particular interest was the extensive leukemic infiltration with atrophy and fibrosis of the posterior lobe of the hypophysis including its capsule (figures 3 and 4). Moderately numerous iron pigment laden macrophages present in the posterior lobe remnant suggested remote hemorrhage into this part of the gland, and recent hemorrhage had occurred into and about the adjacent capsule. A few small foci of fibrosis and leukemic infiltration were present in the comparatively well-preserved anterior lobe.

The immediate cause of death appears to have been the bilateral adrenal hemorrhage, possibly the result of the marked thrombocytopenia or perhaps even adrenal vein thrombosis. The swallowing difficulty noted clinically was apparently due to leukemic infiltration. It is felt that the changes in the posterior lobe of the hypophysis explain the diabetes insipidus.

Some of the more unusual and interesting features of this case were: (1) A temporary remission with busulfan (Myleran®) therapy so complete that even bone marrow examination failed to reveal the disease. (2) Absence of significant hepatosplenomegaly prior to the terminal blastic crisis. (3) Esophageal involvement causing dysphagia and proved radiographically and pathologically; this perhaps a rarer complication than pituitary involvement. (4) Extensive destruction of the posterior lobe of the pituitary gland causing frank diabetes insipidus.

Summary

A case of chronic myelogenous leukemia with clinical and anatomic neurohypophyseal involvement and other interesting features is presented. It is believed to be the first reported in the American literature.

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1185 Broad Street

Doctors Smoking in Presence of Patients

"My position is that smoking in front of a child is contributory to his mental and physical ill health and juvenile delinquency. Children take certain people as their models, especially their therapists. Yet I have seen doctors and others who would be horrified at the suggestion that they take a little cocaine or heroin in front of the children, light and puff away at carcinogenic cigarettes with never a qualm. . . . How in the name of heaven can any honest person want to teach a child who has been committed to his care to risk these dangers?" Karl Menninger, M.D. From: TPR, Publication of the Menninger Foundation.

It appears that in more affluent communities, children tend to be of optimum weight; in poorer communities, there is an excess of both underweight and overweight.

Under-Nutrition and Over-Nutrition in Two New Jersey Communities*

Harvey P. Einhorn, M.D./Newark

This is a report of a project done for the New Jersey Youth Commission, under the auspices of its Nutrition—Fitness Subcommittee. The purpose was to study the state of nutrition of school children as it relates to economic level and report the findings.

Two communities of widely different economic levels were selected. Community "A" was affluent; Community "B" was not.

In Community "A" we studied 477 boys and 441 girls in grades 2, 4, and 6 in seven schools. In Community "B" there were 1,531 boys and 1,479 girls in kindergarten, grades 4, 8, and 10 in eleven schools. Height—weight tables were not utilized; rather, the diagnosis of over or under-nutrition was made by the physician's clinical judgement. The findings are shown in Table 1.

OVERWEIGHT

	Community "A"	*Community "B"*
Boys	2.9%	7.2%
Girls	.9%	12.0%
Total	3.8%	9.6%

UNDERWEIGHT

	Community "A"	*Community "B"*
Boys	0.8%	8.8%
Girls	0.4%	10. %
Total	1.2%	9.7%

Two schools in the relatively less affluent sections of Community "A" accounted for 75 per cent of the overweights and 72 per cent of the underweights.

The breakdown by grades in Community "B" revealed an interesting trend in the overweights shown in Table 2.

	Overweight Boys (%)	*Overweight Girls (%)*
Kindergarten (5-6 yrs.)	6.8	5.7
Grade 4 (9-10 yrs.)	9.9	12.2
Grade 8 (12-14 yrs.)	8.3	13.3
Grade 10 (15-17 yrs.)	4.3	15.0

Note that there is an increase among the boys to age 12 to 14 then a tapering off whereas the girls reveal a steady increase through all the grades.

The more affluent community shows less incidence of under and over-nutrition; however, there is an increasing incidence as the economic ladder is descended even in this community. In the non-affluent community, the incidence of both states of nutrition is increased. It is felt that the trend exhibited by the sexes relates to the increased activity of the boys as they get older and their active participation in sports. The opposite obtains in the girls who, with the inception of teenage, tend to become less active.

* From the Nutrition Subcommitte of the New Jersey Youth Commission.

416 Clinton Place

Snake bites are not common in New Jersey—but when they occur, the doctor has to know what to do, has to do it fast, and has to know how. Here's how.

Comments on Snakebites in New Jersey*

Henry M. Parrish, M.D., Dr. P.H.
Columbia, Missouri

Poisonous snakebites are by no means common in New Jersey. But when a person is bitten by one, the physician is confronted with an emergency which requires knowledge and skill. More people are bitten by poisonous snakes in the Middle Atlantic Region of the United States than many doctors realize. *New Jersey has the second highest incidence of snakebites of the states in this region.* The estimated annual incidence of poisonous snakebites per 100,000 population for these states is: Pennsylvania (0.65), New Jersey (0.41), and New York (0.22). Deaths from poisonous snakebites are rare in New Jersey. None were reported[1] during the ten year period ending in 1959.

Very little has been published about New Jersey's snakebite problem. The comments in this paper are based on a statewide survey of snakebites conducted to provide information about the incidence and pattern of snakebites in New Jersey, to describe other medical findings associated with these bites, and to discuss briefly current concepts of snakebite treatment.

Poisonous Snakes

According to Conant,[2] the following are indigenous to New Jersey: the timber rattlesnake (*Crotalus horridus horridus*) and the

* From the School of Medicine, University of Missouri, Columbia, Missouri. This investigation was supported in part by Public Health Service Research Grant GM 11268-02 from the Division of General Medical Sciences, Public Health Service.

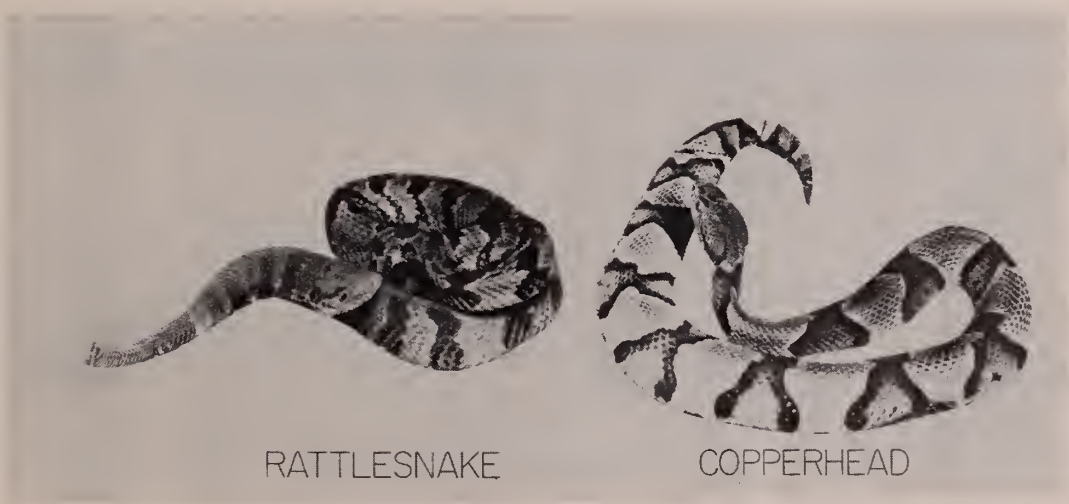


Fig. 1. Poisonous Snakes Indigenous to New Jersey.

northern copperhead (*Agkistrodon contortrix mokeson*). Cottonmouth moccasins and coral snakes are not native to the State. The timber rattlesnake is the most dangerous snake in New Jersey. Large specimens may grow to a length of four to five feet. On the other hand, copperheads are relatively small snakes with an average length of 24 to 36 inches. They have copper color, especially the head, and hour-glass like markings on the side of the body. See Figure 1 for photographs of poisonous snakes of New Jersey.

Timber rattlesnakes and copperheads are pit vipers. They are so named because of a characteristic pit which is located between the eye and nostril on each side of the body. Pit vipers also are identified by elliptical pupils and by two well-developed fangs which protrude from the maxillae when the snake's mouth is opened. Rattlesnakes have rattles which are attached to their tails. Harmless snakes do not have facial pits; they have round rather than elliptical pupils, and while they have teeth, they lack fangs.

Oftentime people will chop off the head of a snake which has bitten someone and bring the snake's body in for identification. Pit vipers can be identified by turning the snake's belly upwards and noting a single row of subcaudal plates just below the anal plate. Harmless snakes have a double row of subcaudal plates. Figure 2 depicts the characteristic features of pit vipers and harmless snakes.

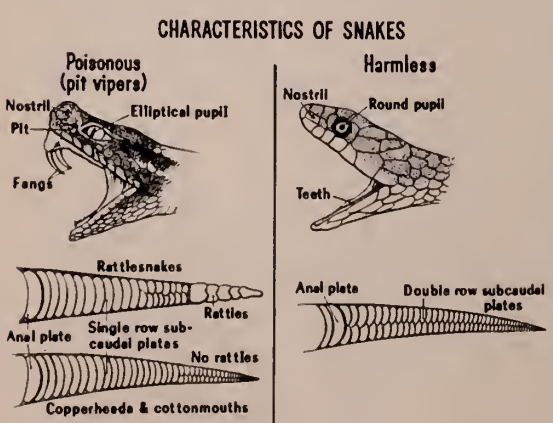


Fig. 2. Characteristic Features of Poisonous (Pit Vipers) and Harmless Snakes.

Methods of Study

A questionnaire and letter were mailed to a group of New Jersey hospitals listed in the American Hospital Association's Guide. We selected general hospitals; children's hospitals; college infirmaries; Army, Navy, Coast Guard, Public Health Service, Air Force, and Veterans Administration hospitals. Maternity, tuberculosis, and mental hospitals were omitted. A total of 94 New Jersey hospitals comprise the study group. Each hospital was requested to report all in-patients admitted for snakebite during 1958 and 1959.

Most hospitals do not code and tabulate the diagnoses of emergency room and out-patient clinic visits. Since some snakebite victims are not admitted to the hospital as in-patients, it seemed essential to ask a sample of practicing physicians how many snakebite victims they treated on both an out-patient (office, home, emergency room, and so on) and on an in-patient basis. Previous surveys,[3,4] have shown that most people with venomous snakebites are treated by general practitioners, surgeons, internists, pediatricians, and orthopedic surgeons. A random sample of one-third of all the New Jersey physicians in these categories of practice who were listed in the American Medical Directory were sent questionnaires.

Death certificates for fatal snakebite cases were obtained from the New Jersey State Department of Health.

Results

This report is based on questionnaires returned by all 94 New Jersey hospitals. It is supplemented by questionnaires returned by 1,031 (69 per cent) of 1,485 practicing physicians in the State. The New Jersey State Department of Health reported that there were no snakebite deaths during 1958 and 1959.

INCIDENCE—New Jersey hospitals reported a total of 20 in-patients treated for poisonous

snakebites during 1958 and 1959. There were eight cases in 1958 and 12 cases in 1959—an average of ten per year. Of the 20 snakebites reported during 1958 and 1959, detailed case reports were received for 13 patients and only numbers of bites were reported for seven cases. *All of the analyses in this paper, excluding the estimate of incidence, were based on the 13 detailed case reports received from hospitals.*

Physicians' reports (adjusted to account for all New Jersey physicians in the relevant practice categories) indicated that 15 in-patients and 10 out-patients were treated for snakebite accidents each year. The difference between the estimate of 15 in-patients treated by physicians and the average of 10 in-patients reported by hospitals can be explained, in part, by the fact that six hospitals under-reported the number of snakebite in-patients treated. Taking all of these into consideration, I estimate that approximately 25 (15 in-patients and 10 out-patients) people are treated annually for venomous snakebites in New Jersey. This provides an incidence of 0.41 bites per 100,000 population per year.

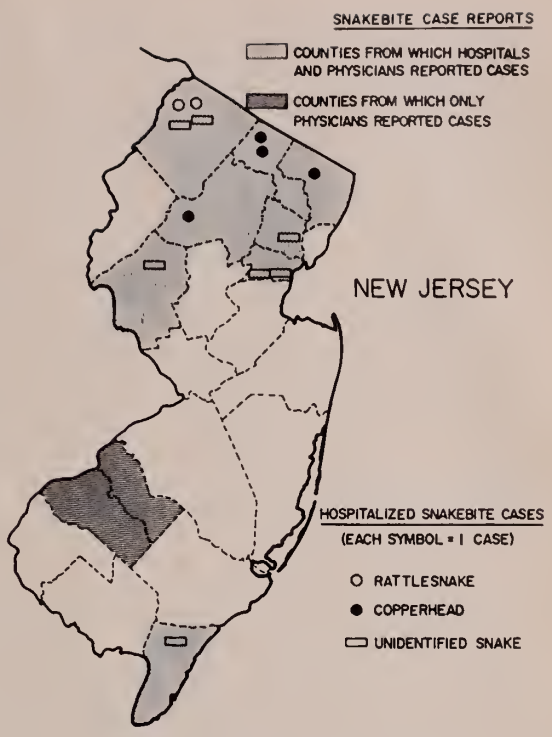


Fig. 3. Geographical Distribution of Poisonous Snakebite Cases in New Jersey, 1958 and 1959.

GEOPATHOLOGY—The geographical distribution of snakebites reported in New Jersey during 1958 and 1959 may be seen in Figure 3. The lightly shaded counties are those from which hospitals reported in-patients treated for snakebites. An appropriate symbol is used to mark each hospitalized patient who was bitten by a specific kind of snake. The darker shaded counties are those counties from which physicians reported snakebite cases, but from which no cases were reported by hospitals.

Of the 13 people hospitalized for snakebite treatment for whom detailed records were available, four (31 per cent) were bitten by copperheads, two (15 per cent) by rattlesnakes, and seven (54 per cent) by unidentified poisonous snakes. Most of the victims of unidentified snakes were children.

Most of the snakebites were reported from the northern third of the State. It seems likely that a high proportion of the bites by unidentified snakes in this area were inflicted by copperheads. Copperheads are confined to the northern half of New Jersey. Timber rattlesnakes have more of a statewide distribution. Most likely the bites reported from the southern half of the State were inflicted by rattlers. The geographic patterns of bites by the various species of snakes are consistent with the ecologic ranges of poisonous snakes in New Jersey.[2]

TEMPORAL RELATIONSHIPS—The monthly distribution of snakebite accidents is shown in Table 1. Snakebites were infrequent during the colder months of the year—November through March. In general, snakes are usually inactive and/or hibernating during the colder months. All of the snakebites in New Jersey were between April and October. This striking seasonal distribution of bites coincides with the time that snakes are most abundant and active and with the time that

people have greater exposure due to out-of-doors occupations and recreation. Similar seasonal epidemics of venomous snakesbites have been observed in New England[3] and Florida.[4] Incidentally, no bites occurred from 12 midnight through 6:00 A.M.

TABLE 1

SEASONAL DISTRIBUTION OF VENOMOUS SNAKEBITES IN NEW JERSEY, 1958 AND 1959

Month	No. Bites	Month	No. Bites
January	0	July	3
February	0	August	5
March	0	September	1
April	1	October	2
May	1	November	0
June	0	December	0

BITE VICTIMS—There were ten males and three females admitted to New Jersey hospitals† for snakebite treatment during 1958 and 1959. Bite rates per 100,000 population were: 0.37 for males and 0.11 for females.

The age distribution of New Jersey bite victims is shown in Table 2. The largest number of bites happened to children and youths 10 to 19 years of age (four bites) and people 50 to 59 years of age (three bites). Fifty-four per cent of all snakebites were inflicted on children and young adults less than 20 years of age. Age-specific bite rates are much more meaningful since they take into account the population at risk in a particular age group. The highest biannual bite rates per 100,000 population were: 50 to 59 years of age (0.46) and 10 to 19 years of age (0.43).

TABLE 2

AGE DISTRIBUTION OF HOSPITALIZED SNAKEBITE VICTIMS IN NEW JERSEY, 1958 AND 1959

Age Group (years)	Population at Risk*	No. Bites	Rate per 100,000**
0-9	1,224,409	3	0.25
10-19	920,743	4	0.43
20-29	683,427	0	0.00
30-39	907,509	2	0.22
40-49	852,860	0	0.00
50-59	654,643	3	0.46
60-69	485,234	0	0.00
70 or more	337,957	1	0.30

* Based on the 1960 Census of the Population of New Jersey.

** These rates are only on hospitalized patients for whom information was available.

† All were white.

Seven were children; and one each was a professional man, a private household worker, a service worker, a retired craftsman, and a housewife. The occupation was not coded for one victim.

ACTIVITY AND PLACE—Two bites occurred while people were walking or working in their own yards. In addition, a child was bitten while playing in his own yard. Two were bitten while handling a poisonous snake, two while camping, two while walking through fields, and one while walking on or near a highway. The activity was not stated for the remaining patients.

The place where the bite accident happened is closely related to the activity when bitten. Three people were bitten in their own yards, three in the woods, three in a field away from the house, and one on or near a highway. The place where the bite took place was not coded for three patients.

SITE AND SEVERITY—The anatomic sites on human beings where venomous snakes inflicted their bites are shown in Table 3. All of the bites were inflicted on the extremities: 69 per cent on the upper extremities and 31 on the lower. The fingers were the parts most often bitten on the upper extremities. The lower legs, including the ankles, were the parts most frequently bitten on the lower extremities.

TABLE 3

SITES OF BITES

Head, face, neck, toes, upper arm or trunk	0
Forearm	2
Hand	2
Fingers	5
Ankle and lower leg	3
Foot	1

Bites were classified[5] as follows:

Grade 0—*No venenation.* Fang or tooth marks, minimal pain, less than 1 inch of surrounding edema and erythema. No systemic involvement.

Grade I—*Minimal venenation.* Fang or tooth marks, severe pain, 1 to 5 inches of surrounding edema and erythema in first 12 hours after bite. No systemic involvement usually present.

Grade II—*Moderate venenation.* Fang or tooth marks, severe pain; 6 to 12 inches of surrounding edema and erythema in first 12 hours after bite, systemic involvement may be present: nausea, vomiting, giddiness, shock or neurotoxic symptoms.

Grade III—*Severe venenation.* Fang or tooth marks, severe pain, more than 12 inches of surrounding edema and erythema in first 12 hours after bite, systemic involvement usually present as in Grade II.

The severity of venenation (venom poisoning) was classified as follows for 13 hospitalized cases: 6 (46 per cent) were Grade 0; 5 (38 per cent) were Grade I; 1 (8 per cent) was Grade II; and 1 (8 per cent) was Grade III. There were no deaths among the 13 hospitalized cases in this series, nor among the estimated 25 snakebite cases that occurred annually in 1958 and 1959. The case-fatality rate for poisonous snakebites in New Jersey is estimated to be less than one-fourth of one per cent. This is confirmed by the fact that there were no snakebite deaths in New Jersey from 1950 through 1959.[1] Rattlesnakes (*Crotalus sp.*) cause more deaths than any other poisonous snakes in the United States.[6] There were no deaths in the United States definitely attributed to copperheads between 1950 and 1959. However, this does not mean that copperhead bites are not occasionally serious or are not potentially lethal.

Treatment

The current treatment of North American pit viper (rattlesnake, cottonmouth moccasin and copperhead) bites includes both minor surgery and medical forms of treatment. A constricting band (tourniquet) should be applied lightly to the involved extremity several inches proximal to the bite. The constricting band should be tight enough to occlude the superficial venous and lymphatic flow. *It should not occlude the arterial circulation.* It should be released every 10 to 15 minutes for a minute or two. As edema resulting from venom poisoning spreads, the constricting band should be advanced to keep just ahead of the swelling. Purpose of the constricting band is to impede the spread of venom until incision and suction can be used to remove the venom mechanically and/or until antivenin can be administered to neutralize the venom.

Incision and suction (I.S.) is effective in removing venom from experimental animals up to about 120 minutes after the venom is injected. The sooner it is used, the larger the amount of venom that can be removed. Suction should be used for about one hour. We have found the suction cups supplied in the Cutter® and the Becton-Dickinson® snakebite first-aid kits effective for removing pit viper venom. Incisions, one-quarter inch long and one-eighth to one-quarter inch deep, are made into the subcutaneous tissues over the fang punctures. A few (3, 4, or 5) additional incisions may be made in the surrounding edematous tissues. A large number of incisions is not needed. Immobilization aids in limiting the spread of venom. However, if one must decide between immobilization or seeking prompt medical treatment, the latter should be sought.

The "3 A's" (antivenin, antibiotics, and tetanus antitoxin and/or toxoid) are recommended, in addition to incision and suction, in treating all serious pit viper bites. Antivenin Crotalidae Polyvalent® (Wyeth) is effective in neutralizing the venoms of all North American pit vipers. It is not protective against coral snake venom. Since antivenin is manufactured from horse serum, the patient should receive a skin test before antivenin is given. For Grade I venenations, antivenin may be administered in the deltoid or gluteus muscles. In Grade II and Grade III venenations, antivenin diluted in 1000 cubic centimeters of normal saline may be given intravenously.[7] Studies with radioisotopes have shown that antivenin accumulates at the site of the bite more rapidly after intravenous administration than after intramuscular administration.[8] Injection of antivenin into the

local bite area is not a particularly effective way to administer antivenin. We have found the following amounts of antivenin useful in treating the various Grades of venenation: Grade 0 (no venenation) requires no antivenin; Grade I (minimal venenation) may require 10 cubic centimeter (one ampule) of antivenin; Grade II (moderate venenation) requires 30-40 cubic centimeter of antivenin; and Grade III (severe venenation) requires 50 cubic centimeter or more of antivenin.

Since snakes' mouths and venoms may harbor pathogenic organisms, antibiotics and tetanus antitoxin and/or toxoid should be given prophylactically. Gram negative organisms predominate, hence a broad spectrum antibiotic is indicated. Penicillin used by itself is not adequate treatment.

Cortisone and ACTH do not affect the survival rate of animals poisoned with pit viper venom. They probably should not be used during the first few days after venenation, although they may be beneficial later in treating serum sickness resulting from antivenin therapy. Antihistamines are contraindicated as they shorten the survival time of animals poisoned with pit viper venoms. Shock resulting from venom poisoning should be treated with infusions of blood, plasma, saline solution and vasopressor drugs. Meperidine hydrochloride and other analgesics may be given to relieve pain. Recently there have been reports of excessive tissue necrosis and amputations associated with cold therapy such as packing an extremity in ice or using ethyl chloride.[8] In our opinion, cold therapy should not be used in treating pit viper bites.

Summary

An estimated 25 people are treated annually for venomous snakebites in New Jersey. Of these, 15 are admitted to hospitals for treatment and 10 are treated on an out-patient basis in hospital emergency rooms and in physicians' offices.

Of 13 in-patients reported by New Jersey hospitals during 1958 and 1959, four (31 per cent) were bitten by copperheads, two (15 per cent) by rattlesnakes, and seven (54 per cent) by unidentified poisonous snakes. Seasonal epidemics of snakebites occurred with all of the bites inflicted from April through October.

Males had higher bite rates than females and whites had higher rates than non-whites. Fifty-four per cent of the cases were among children and young adults less than 20 years of age. All of the bites were on the extremities: 69 per cent on the upper extremities. Current snakebite treatment is discussed.

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The author cites with gratitude the technical assistance of Judi Pummill, Linda Hinson, and Genevieve Calescibetta.

The University of Missouri

Nausea and vomiting after breathing in smoke is actually due to ingestion and should be treated with antacids.

Smoke Poisoning Treated By Antacids

Murray Levin, M.D./West Orange

It is my intent, with this paper, to present further observations on the treatment of smoke poisoning from continued experimentation and experiences since the last paper was published.

Consider a fireman who enters a burning building and is exposed to smoke from burning materials. If the concentration of smoke in the atmosphere is small (compared to the total cubic feet of air), the volume of smoke will pass by the larynx and will be inhaled. As the concentration of smoke increases in proportion to the volume of air and as the particles become closer together, the laryngeal mucous membrane (which is very sensitive to irritants) will be triggered into a spasm occluding larger particles.*

The irritation of the larynx causes choking, coughing, and gasping. Reflexly, gulping and swallowing of air takes place. The laryngeal spasm cannot be maintained for any length of time. It is overcome by the body's convulsive instinctive desire to remain alive. Therefore, the larger particles are inhaled to a degree producing further spasm and coughing.

One of the ingredients of this complex material called smoke is carbon monoxide—a tasteless, odorless, colorless gas with a molecular weight of 28. This gas combines with the hemoglobin of the red blood cells to form carboxyhemoglobin, a very stable compound. The hemoglobin is thus prevented from picking up molecules of oxygen and circulating the resulting oxyhemoglobin throughout the circulation.

One of the first symptoms of carbon monoxide poisoning is headache—probably because the brain is deprived of oxygen. Later on, this is followed by weakness, dizziness, prostration coma, and death. No where is nausea an early symptom. In carbon monoxide poisoning, nausea is rare or non-existant. In not one of the many cases of suicide that I have seen (either by gas or auto exhaust fumes), has there been evidence of nausea or vomiting. The nausea from smoke poisoning must come from a different source.

Incidentally, the treatment of carbon monoxide poisoning is the administration of large doses of oxygen in concentrations that will enable the carboxyhemoglobin to be displaced by oxyhemoglobin and with the new hyperbaric type of administration of oxygen, this will become the treatment of choice in carbon monoxide poisoning.

Smoke, a multivaried substance, is the breakdown product of burning materials. It consists of complex acids which are irritating to the larynx, producing spasm and ultimate choking, coughing, and swallowing of smoke. In the battle for survival, smoke ingested in this form produces gastric irritation which is readily neutralized by any antiacid. Dr. Albert Crosby of the Norfolk, Virginia Fire Surgeon's

* Sodeman, William A.: Pathological Physiology. Philadelphia, Pa., 1961, Saunders, Page 633.

office wrote me of the following experience:

On May 15, 1964, I had a real opportunity of testing your theory. There was a dock side fire on the S.S. *Steel Fabricator* involving a cargo of jute and burlap. The firemen took a lot of punishment. The fire was not controlled for several days. At the nearby hospital, I was able to pass the word along to the house staff about the difference between smoke inhalation and smoke ingestion. Having several cases of both conditions, I was able to demonstrate the difference and the responsiveness to use of antiacids in smoke ingestion. All of the local emergency rooms stock a so-called "G.I. Cocktail" which contains magnesium-aluminum hydroxide, elixir phenobarbital, and tincture belladonna. This was given in all of the emergency room cases. Magnesium-aluminum hydroxide was used at the scene of the fire. It helped materially in reducing the incidence of cases needing emergency room care.

I have used calcium carbonate in the form of a chewable tablet, easily carried by firemen. It needs no bottles or spoons to administer. Nausea and vomiting rapidly vanish. This supercedes the administration of oxygen which does nothing for the gastric symptoms, but which is not to be underestimated in the treatment of an associated carbon monoxide poisoning. If a fireman is brought out from a fire complaining of severe headache without nausea or vomiting, he is, in all probability, suffering from carbon monoxide poisoning of which there are all degrees from headache to unconsciousness. On the other hand, if his symptoms are those of nausea and vomiting he has no doubt ingested considerable quantities of smoke and requires some antiacids. If in doubt, both oxygen and antiacids may be given provided the patient is able to swallow and is not unconscious.

If there has been a great concentration of smoke together with heat and flames, further irritation of the larynx and bronchial mucous membranes may take place with the development of pulmonary edema. This must be treated by immediate removal from the smoke area, administration of oxygen in large quantities combined with a sterile aqueous solution for aerosol use containing the detergent tyloxapol 0.125 per cent with 2 per cent sodium bicarbonate and 5 per cent glycerin and racemic epinepherin hydrochloride together with the use of diuretics and digitalis if there is evidence of congestive heart failure. Antibiotics and intravenous fluids are also advised, if necessary.

Little research has been done in this branch of medicine, and many a firefighter has been content to have an oxygen mask placed on his face when he was assisted from a fire nauseated and vomiting from the ingestion of too much smoke. Let it be recognized that smoke can be ingested as a reflex secondary to laryngeal spasm. Once this is accepted, a large step forward in the treatment of smoke poisoning will be taken by the medical profession.

96 Washington Street

Association For Brain Injured Children

An Association for Brain Injured Children has been formed and is headquartered at 61 Lincoln St., East Orange. (Phone: OR 5-1709, area code 201). It sponsors day camps for these children, and helps establish special classes within the public school system. It aims to educate the public as well as the teaching and medical professions in the peculiarly poignant problems of brain-damaged children. We know what the National Foundation and the National Tuberculosis Associations have done for disabilities in their areas of interest; and given good public and professional support, the new Association of Brain Injured Children should do the same. Write to the section chairman nearest you:

Paramus: Mr. Leon Klein, 207 Wilsey Court.
Millburn: Mrs. Beatrice Antell, 930 Ridgewood Road
Princeton: Mr. Thomas A. Jones, 73 Brookstone Drive
Butler: Mr. James Mullen, 24 Siek Road
Rumson: Mrs. William Lee, 1 Popomora Drive
Cliffside Park: Mr. Charles Loomer, 43 Washington Avenue

This is the first para-duodenal hernia encountered in Mercer Hospital's autopsy history.

Para-Duodenal Hernia

Edmund Burroughs, M.D.
Alfred Schwager, M.D.
Thomas K. Rathmell, M.D. / **Trenton**

A 78-year-old woman had two admissions to The Mercer Hospital. She weighed only 85 pounds and was 5 feet tall. On her first admission, she had had severe pain in the right upper quadrant with radiation to the periumbilical area for about nine days. On four occasions (in the 5 years prior to that admission) similar episodes of pain and jaundice were noted. This was accompanied by nausea, vomiting, and some degree of fever. She had experienced these episodes intermittently for many years, and a diagnosis of acute exacerbation of chronic cholecystitis was made.

At the time of her first admission, blood pressure was 200/120. Her abdomen then presented localized tenderness in the right upper quadrant. There were no appreciable masses noted in the abdomen. At this time she had an icterus index of 14.5 units, and her blood urea nitrogen was 27 mgs. per cent. She was then treated with parenteral fluids and analgesic agents, and she showed progressive improvement and was discharged within a week.

Her second admission was a year later. She had severe upper abdominal pain which became intense on the day previous to her hospitalization. On this admission, she showed tachycardia with an irregular cardiac rate. Blood pressure was 180/120. The abdomen was distended and tender throughout. Peristalsis was not elicited. Rectal examination revealed no masses.

A blood count showed 30,800 leukocytes with 95 per cent neutrophiles. Of these, 48 per cent were immature types; and there were 5 per cent lymphocytes. A portable flat plate of the abdomen showed distention of the small bowel, as well as distention of the right and transverse colon. This was interpreted as probably due to the obstruction of the distal colon, but the possibility of mesentery artery thrombosis could not be excluded. The electrocardiogram showed atrial fibrillation with a ventricular rate of 98 beats per minute. Prolongation of the QT interval suggested hypokalemia.

Abdominal pain became progressively more intense. She stated that this pain was different from her "usual" gallbladder discomfort, in that she interpreted it as generalized in type. Her abdomen was tender in all quadrants. She had a significant rebound phenomenon. The abdomen was distended.

Surgical intervention was rejected because of her poor physical condition. Therapy consisted of maintenance digitalis, parenteral fluids, whole blood transfusions, and chloramphenicol. Her condition rapidly deteriorated, and she expired within 24 hours of the readmission. Death was attributed to either an acute cholecystitis with rupture of the gallbladder, or a mesenteric thrombosis.

At autopsy,* the stomach was found to be twice its normal size. It contained undigested greenish fluid material with a foul odor resembling intestinal contents. The duodenum was distended to twice its normal size, having a perimeter of 9 centimeters. Its serosal surface was covered by a greenish membranous

* The postmortem examination was performed by George Mora, M.D.

exudate. The lumen was filled with greenish material having an extremely foul odor. The ampulla of Vater was permeable.

The entire jejunum and a portion of the ileum had herniated through the mesenteric wall about the ligament of Treitz, forming a sac in the left side of the abdominal cavity below the transverse colon, measuring 20 centimeters in its largest diameter. On section, the hernial sac had a thickness of 2 millimeters and showed prominent vascular channels. The jejunum at this level showed advanced



necrosis with a bright red color, and was adherent to the hernial sac by multiple necrotic fibrous adhesions. The jejunum exhibited at the mesenteric edge numerous diverticuli. The largest one was 4 centimeters in diameter. The hernial sac (through which the intestine had been strangulated) opened towards the right side of the body. This sac was on the left side of the abdomen. The superior mesenteric vessels formed a ring around the right side of the hernial orifice and were compressed by its contents. The intestine within the hernial sac was friable, showed advanced ischemic necrosis, and contained hemorrhagic fluid material in its lumen. Death was due to a strangulation of the left para-duodenal hernia with resulting intestinal obstruction, mesenteric thrombosis, and generalized acute peritonitis. Multiple calculi were found in the gallbladder.

Para-duodenal hernias have not been encountered previously in our post-mortem experience. However, they are said to be present in over one-half of the intra-abdominal hernias. A complex system of fossae has been observed about the duodenum due to the different types of incomplete fixation of the mesenteries of the small intestine and colon. These hernias may be classified as either left or right para-duodenal hernias. When the greater part of the small bowel is enclosed in the sac, the features of the peritoneal cavity may be quite confused, and the surgeon who attempts to repair it must be very careful with his dissection to be certain that no damage is done to the blood supply of the bowel. The anterior wall of the sac is formed by the mescolon. If the sac is on the left (which is the more common occurrence), the mass of intestine is to the left of the midline, the opening is directed toward the right, and the inferior mesenteric vein usually courses along the antero-medial margin of the sac. This rare and unusual intra-abdominal hernia, in our experience, is illustrated in the accompanying photograph.

446 Bellevue Avenue (Dr. Rathmell)

Dr. James Gleason Made ACP Governor

Dr. James P. Gleason of Ventnor was recently elected Governor for New Jersey for the American College of Physicians. He succeeds Dr. Leroy M. Black of Rutherford, who had been the Governor for this state for the past six years.

Fortunately, most of the dire predictions about continuing pregnancy during illness do not come true. Here is another example.

Anti-Tuberculosis Therapy During Pregnancy*

Charles Hyman, M.D.
Lawrence A. Wilson, M.D. / **Northfield**

There has recently been widespread concern about the effects of therapeutic agents on the growth and development of the human fetus. This has led to a critical review of drugs administered during pregnancy, especially during the first trimester. Female patients with active, treated tuberculosis are of special interest with respect to possible teratogenic effect of these drugs because they are exposed to continuous drug therapy throughout pregnancy.

The following report documents such a case. This patient was treated with ethionamide and pyrazinamide throughout pregnancy and subsequently gave birth to a normal fetus.

A 32-year-old woman was admitted to Atlantic County Hospital for Tuberculous Diseases on February 21, 1961. She had been ill for three weeks with fever, chills, weakness, painful cough, and mucoid expectoration. She had had four normal pregnancies, the children now ranging in age from 6 to 12.

She had a strong family history of pulmonary tuberculosis.

On admission, she was emaciated. She was extremely emotional, and there was difficulty in getting her history. Admission weight was 99 pounds, and her temperature was normal. The thorax was symmetrical, and expansion appeared equal. There was lagging of her respiratory excursion on the left side and impaired resonance over the left upper lobe. Breath sounds were bronchial in type and accompanied by crackling rales at the end of the inspiration. The whispered voice was increased. Examination of the heart was negative except for a sinus tachycardia of 110 beats per minute.

The blood pressure was 110/80. Remainder of the physical examination was unremarkable.

X-ray examination disclosed an almost opaque homogenous infiltration occupying the area of the left upper lobe between the first and third ribs. Within this area there was a faintly outlined, rounded density 3 centimeters in diameter, representing a cavity. Bronchoscopic examination revealed no endobronchial disease. Routine laboratory studies were within normal limits. Bacteriologic examinations of the sputa were repeatedly positive for acid-fast bacilli.

The patient was placed on a therapeutic program of isoniazid 100 milligrams three time a day; PAS sodium 4 Grams 3 times a day; and streptomycin one Gram twice a week. Clinical response was good, with improvement in mood and appetite, and a weight gain of 18 pounds. The sputa converted to negative after one month of treatment and remained negative until August 1961 when a Gaffky count varied from 1 to X. Serial x-ray films of the chest (which had shown some early resolution) now demonstrated that the previously described cavity had become larger without, however, involving other portions of the lungs. Tomography revealed an irregularly shaped, thin-walled cavity about 4 centimeters in diameter which was visualized in planes 3 to 7, indicating its depth at 4 centimeters. The remaining lung fields were clear of disease.

On May 8, 1962, the patient was transfered to the Atlantic City Hospital for a left upper lobectomy. She was placed on cycloserine, INH, and pyrazinamide in preparation for surgery. The patient was returned to the Atlantic County Hospital on June 3, 1962. Her physical condition was good, and x-rays after surgery were reported as showing no evidence of pulmonary tuberculosis and exhibiting thickening of the pleura over the left hemithorax. She was continued on cycloserine, INH, and pyrazinamide. Sputa smears and cultures were negative until September 1962, when a Gaffky II appeared, and continued positive until December 18, 1962, when the patient was placed on ethionamide 500 milligrams twice a day. The other anti-tuberculosis drugs (except pyrazinamide 1½ Grams a day) were discontinued. There were no untoward symptoms except some early morning nausea.

On January 13, 1963, it was established that the patient was pregnant. Her sputa continued positive during pregnancy, and her Gaffky count was as high as VII. On August 15, 1963, she was delivered of a full-term infant weighing 8 pounds. Post-partum course was un-

* From the Atlantic County Hospital for Tuberculous Diseases at Northfield, N. J.

remarkable. The infant appeared normal at birth. Subsequent examinations of the child confirmed this impression. The growth and development of the child have been normal, and there is no evidence of any type of congenital abnormality.

Tomograms on September 10, 1963, confirmed the presence of active disease of the left upper lung, with a 35 millimeter cavity behind the first anterior interspace. By reason of recurrent disease in the left lung and a normal right lung, a left pneumonectomy and an eight-rib thoracoplasty were done September 23, 1963. Sputa have been negative on examination since that time. The patient's physical condition has improved, and there has been a satisfactory weight gain of 18 pounds.

Ethionamide was continued until October 13, 1963, and the patient has been subsequently maintained on isoniazid 300 milligrams a day.

A case report is presented, describing the birth of a normal child after a woman had been under treatment with ethionamide and pyrazinamide throughout her pregnancy.

Atlantic County Hospital for Tuberculous Diseases

Cigaret Deaths Going Up In Netherlands

A statistical review of variations in mortality in the Netherlands over a 12-year period compares rising male and declining female rates with different levels of smoking. The death rate from all causes for men rose from 77 per 10,000 population in 1950 to 87 in 1962, while female rates declined from 72 to 70. The increase in male death rates was entirely accounted for in the 55-69 year age bracket. The sex difference in mortality ratio for age 50-69 is accounted for by higher male mortality from coronary artery disease, cancer of the lung, bronchus and trachea, respiratory diseases and peptic ulcer, all diseases influenced by smoking.

Whereas 62 per cent of women do not smoke, only 10 of Netherlands males are non-smokers. Total tobacco consumption data show that 10 times as many cigarets as cigars per capita are consumed annually. Dr. Vader concludes that "the very important excess mortality of the Netherlands male at an advanced age as compared with the female is indeed caused by smoking." Vader, V. V. *Medical Officer,* 112:153 (1964)

Church Honors Two Blue Shield Trustees

Last month, two Medical-Surgical Plan Trustees received honors for their careers and achievements in medicine.

Dr. Edward W. Sprague, a pioneer New Jersey surgeon, a founding father of Medical-Surgical Plan and a Trustee since the Plan's inception, was made a Knight of St. Sylvester in the Roman Catholic Church in recognition of his long service on the surgical staff of St. James Hospital. Dr. Sprague, a Protestant, was presented with a symbolic medal by Archbishop Thomas J. Boland in Papal Award ceremonies at Sacred Heart Cathedral, Newark.

Dr. Joseph P. Donnelly, a Plan Trustee since 1953, was given Catholic University's Achievement Award in Medicine at the university's diamond jubilee celebration. A distinguished obstetrician, Dr. Donnelly was a member of the university's class of 1928, before receiving his M.D. from Yale. He is medical director of Margaret Hague Maternity Hospital, Jersey City, a Trustee of The Medical Society of New Jersey, and a past president of the Hudson County Medical Society.

Don't rush for the scalpel at the first suggestion of gallstones. It might be cholestatic hepatitis.

Cholestatic Hepatitis (Viral?), Mimicking Silent Common Duct Stone

Morton J. Silk, M.D./Morris Plains

It has long been known[1] that some cases of viral hepatitis are characterized by obstructive jaundice, so called "cholestatic hepatitis." Some epidemics have been characterized by a high incidence of this type of case.[2] This variety of liver involvement can be caused by certain drugs, including chlorpromazine, chlorpropamide, methyltestosterone, northandrolone, and erythromycin estolate. It is also a rare recurrent syndrome of unknown etiology with onset very early in life.[3]

The following case of obstructive jaundice, presumably of virus etiology, is presented because of its relatively pure cholestatic features, the occurrence of which is apparently not widely appreciated by clinicians either here or abroad.[4]

A 16-year-old boy was admitted to Morristown Memorial Hospital with increasing jaundice and a rash of five days' duration. The illness started one week before admission with mild malaise and headache, for which he took a total of four tablets of aspirin as the only medication. Several days later a maculopapular rash developed over the face and trunk. He then had a mildly injected pharynx and slight post-nasal mucoid discharge, but was afebrile. No medications were given. The presumptive diagnosis was rubella, which was then epidemic in the community. Three days later, the patient was seen again because the rash had become more extensive and plaque-like, especially on the neck. It no longer looked like German measles. He felt well except for anorexia and had vomited only once. At this time, icteric sclerae were noted, and the patient was hospitalized.

Past history was essentially negative except for an appendectomy two years ago, following a typical appendicitis. Sulfa drugs produced mild allergic symptoms (eyelid swelling) during early childhood. He had received no injections the past year, nor has there been known exposure to viral hepatitis or rodents. His father has allergic rhinitis with nasal polyposis. There was no family history of illness similar to patient's either before or after the patient's illness.

On admission he was an obviously jaundiced youth who did not appear acutely ill. His temperature was normal, pulse was 76, and blood pressure 110/70. There was a pink maculopapular rash over his face, neck, and trunk, with nummular patches and some crusting and peeling in several areas, especially around the neck. There were a few shotty posterior cervical and axillary lymph nodes, slightly tender to palpation. The pharynx was not injected at this time. Lungs, heart, and abdomen were negative. Neither the liver nor the spleen were palpable at this time, nor was there any pain on percussion over the liver area. No signs of meningeal irritation were present, and the neurologic exam was otherwise negative.

Laboratory data on admission showed a hemoglobin of 15 grams; white-cell count was 4,000, with 63 per cent neutrophiles and 7 per cent eosinophils, the remainder being lymphocytes, including a few atypical forms. Urine showed about 20 red blood cells, a trace of albumen, and a positive test for bile. Total serum bilirubin level was 8.3 milligrams per 100 millilitres with a direct fraction of 5.6 milligrams. Initial Transaminase (SGOT) level was 250 units per milliliter. Three days later, blood count showed a total white-cell count of 4,400 with 2 per cent eosinophils; urinalysis was negative. VDRL and a chest plate were both negative.

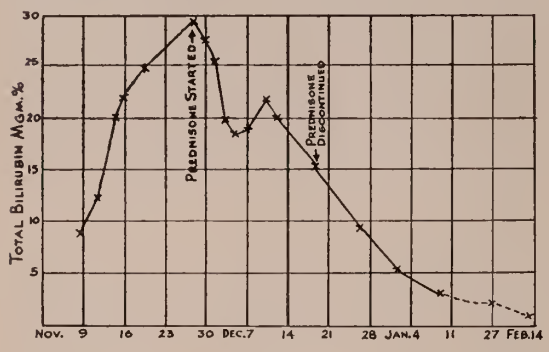
Initial impression was infectious mononucleosis with liver involvement. Following admission, the jaundice deepened, though the mild anorexia and malaise disappeared and he remained essentially asymptomatic and afebrile. The rash gradually subsided in four days, though fine desquamation was present for an additional week. The spleen, and later the liver, became minimally palpable and tender at the end of the first hospital week, and then gradually became non-palpable. Serial blood smears and heterophile agglutination tests were negative for infectious mononucleosis. Cephalin flocculation and thymol turbidity tests, done at weekly intervals, were negative.

The bilirubin rapidly rose to a total of 29 milligrams per 100 milliliters (direct fraction 25) at the end of the third week of illness. It remained above 20 for two weeks, and then gradually fell to normal by the end of four months. Starting on the ninth day of hospitalization, we administered 40 milligrams of prednisone daily (because of reports[1] of favorable effect on viral hepatitis which was now our working diagnosis). This seemed to have a favorable effect on the bilirubin curve initially, but the bilirubin level was still 20 at the time of discharge one month after admission. The alkaline phosphatase levels paralleled the bilirubin, reaching a height of 25 units per milliliter. Surgical exploration for common duct stone was advised by two

observers because of prominent obstructive features. But it was decided to treat the patient conservatively.

The highest transaminase level was 390 (SGPT) and 220 (SGOT) on the seventh day. On the ninth day, the cholesterol was 430 milligrams per 100 milliliters with 51 per cent esters; sedimentation rate was 30 millimeters (Westergren); prothrombin time 17.8 seconds (control, 14.8); protein electrophoresis showed a normal curve. Hemoglobin values, reticulocyte count, red cell fragility tests were all normal. The stools, which were clay colored at the height of the jaundice, were negative for ova and parasites. No evidence of virus infection was found by inoculation into monkey kidney and Hela cells by the State Board of Health Laboratories. An upper gastrointestinal series was negative.

Besides prednisone, therapy was purely supportive and symptomatic, including vitamin supplements and trimeprazine (Temaril®) for relief of itching which developed during the third week of hospitalization. At the time of discharge one month after admission, the patient was symptom free, though deeply jaundiced. His bilirubin was 20 milligrams per 100 milliliter, with his appetite remaining excellent. He was continued on a program of limited activity in his home, and his bilirubin level was determined at weekly intervals. The prednisone, which was being given at a dosage of 20 milligrams daily at the time of hospital discharge, was gradually stopped over the next two weeks. Cholecystogram was deferred until the bilirubin came down to normal four months after the onset of illness, and then was completely normal. One month later, a bromsulfalein test showed 11.3 per cent retention in 45 minutes. There was no recurrence of symptoms in nine month follow-up. One year after onset of illness, the bromsulfalein test showed 2 per cent retention in 45 minutes.



This case of cholestatic jaundice presents several unusual features. The initial symptoms of mild pharyngitis, lymphadenapathy, and skin rash suggest a viral etiology, although there was no increased incidence of hepatitis in the community at the time. I have never heard of the virus of rubella producing hepatitis. The transient mild eosinophilia and rash might also suggest a toxic or allergic cause, but no historical evidence of this could be elicited by several consulting physicians. Aspirin, the only medicine taken prior to the onset of jaundice, has never, to our knowledge, been implicated as a cause of jaundice. The completeness and the prolongation of the obstruction, evidenced by high direct reacting bilirubin and alkaline phosphatase levels, and absence of significant laboratory signs of hepatocellular damage, would propel one into a surgical exploration which is considered hazardous in this type of case.

Cortisone was formerly advocated as a therapeutic test in similar cases,[2,4,5] since it was thought that a dramatic response indicated a viral etiology. However, recent reports[5] deny that this is always so. Johnson and Duenges[1] cite an epidemic of viral hepatitis which, in many cases, had predominantly obstructive features and scanty signs of hepatocellular damage. These cases were characterized by relative freedom from symptoms, absence of fever and appreciable hepatomegaly, and a greater incidence of splenomegaly and normal flocculation and turbidity tests. All of these characteristics were present in our case. In these cases the jaundice, besides being more intense, is more prolonged (2 to 4 months), while a duration of two to four weeks is more typical of usual hepatocellular type of jaundice, or the type caused by drugs.

Summary

A case is presented of a sixteen year old boy with severe, prolonged, obstructive-type jaundice with negative flocculation tests and few signs of hepatocellular jaundice. It was thought to be of viral etiology. The temptation to resort to surgical exploration was resisted and the patient made a complete, though delayed, recovery with bilirubin falling to normal in four months. A cholecystogram was negative, and there has been no recurrence of symptoms in nine months.

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374 Speedwell Avenue

A 44 per cent survival rate in abdominal aneurysms that had already ruptured is the remarkable record here reported.

Ruptured Abdominal Aortic Aneurysm

Franklyn P. Gerard, M.D.
Adrian M. Sabety, M.D.
Robert De Marco, M.D. / **Newark**

Abdominal aortic aneurysms have been successfully resected and replaced by various graft materials to restore circulatory continuity since 1951. At that time, Dubost[1] and his associates reported the first successful case. Until that time many unsatisfactory methods of therapy had been tried. These included the insertion of needles into the aneurysm to produce thrombosis[2] and wrapping the aneurysm with polyethylene film to produce periarterial fibrosis[3].

In 1953, DeBakey and Cooley[4] reported a series of abdominal aneurysms successfully resected and replaced by homografts. The mortality at that time for elective cases was 30 per cent. Over the past ten years, due to refinements in surgical technic and pre and post operative management, as well as the use of synthetic graft materials, the mortality rate in elective cases has been reduced[5] to less than 10 per cent. While this lowering of the mortality rate is encouraging, the surgical treatment of a rupture or "leaking" abdominal aneurysm still brings with it a high surgical mortality. Roberts and MacVaugh[6] in 1961 reported 26 ruptured aneurysms with only four survivals: a survival rate of 15 per cent.

This present report deals with the authors' personal experience in 16 cases of ruptured abdominal aortic aneurysms resected at local community hospitals, with seven long term survivals, for a survival rate of 44 per cent.

Material

Between January 1, 1960 and September 1, 1964, sixteen cases of ruptured abdominal aortic aneurysm were explored and resected. A number of other cases were examined and diagnosed, but died before they could be brought to the operating room. These are not included in this survey. Only patients who actually leaked blood into the peritoneal cavity or retroperitoneal space are included in this series. Cases of so-called expanding aneurysm with no evidence of free blood are not included in this study, but will be reviewed in a subsequent report of elective aneurysms.

Only two of the 16 patients were female. For the whole series, the ages ranged from 57 to 83 years with only one in the 50 to 60 year range. The highest incidence occurred in the 60 to 70 year group with a total of seven cases. The 70 to 80 year group accounted for 6 cases, and there were two over the age of 80.

Diagnosis

Early diagnosis offers the best chance for survival. The most salient features in history and physical examination which aid in this diagnosis are:

1. *Pain.* Back or abdominal pain. This is not colicky in nature but rather a steady gnawing, persistant symptom which may vary in its intensity.

2. *Shock.* Some degree of shock was apparent in all cases. (Table 1). Numerous instances of syncope

Case	Age	Sex	Admission Diagnosis	Back Pain	Abdominal Pain	Shock	Mass	Femoral Pulses	Symptoms Prior To Surgery	Survival
1	68	M	Ruptured Aneurysm	++++	0/+	++++	+	+++	4 Hours	+
2	57	M	Coronary Occlusion	++	++++	++++	−	++	12 Hours	−
3	67	M	Acute Diverticulitis	++++	+++	++++	−	++	12 Days	−
4	61	M	Ruptured Aneurysm	+++	++++	++++	+	+++	4 Days	−
5	64	M	Ruptured Aneurysm	+++	++++	++++	+	+++	3 Hours	+
6	72	F	Nephritis	++++	++	++++	−	++	10 Days	−
7	72	M	Intestinal Obstruction	++	++	++++	+	+++	2 Days	+
8	82	M	Acute Low Back Strain	++++	0	++++	+	++	8 Hours	−
9	77	M	Ruptured Aneurysm	++++	0	++++	+	++	3 Days	−
10	64	M	Ruptured Aneurysm	++++	++++	++++	?	+	5 Days	+
11	68	F	Ruptured Aneurysm	++++	++++	++++	+	+	10 Hours	−
12	76	M	Ruptured Aneurysm	0	++++	++++	+	++++	12 Hours	−
13	74	M	Ruptured Aneurysm	?	++++	++++	+	++++	2 Weeks	+
14	83	M	Ruptured Aneurysm	0	++++	++++	+	++	24 Hours	−
15	76	M	Ruptured Aneurysm	++++	++++	++++	+	+++	4 Hours	+
16	62	M	Intestinal Obstruction	0	+++++	+++	+	+++	6 Hours	+

were reported. The degree of shock had no specific relationship to the severity of the situation. In several cases (3, 6, 9, 12, and 16) one brief episode of shock was reported which responded merely to glucose therapy. Several patients were transported to x-ray for survey films, only to fall into profound irreversible shock after movement onto the x-ray table. In one instance (case 4), abdominal aneurysm had been diagnosed one year prior to rupture. Elective surgery was deferred because the patient had had one coronary, two cerebrovascular accidents, and also had x-ray evidence of an expanding thoracic aneurysm. He fainted several times at home over a three-day period before seeking medical aid. Amazingly, he survived seven days following resection of the aneurysm only to expire due to renal shut-down.

3. *Palpable Mass.* In most instances, a pulsating palpable mass will be apparent on examination. However, in three of our cases (2, 3, and 6), due to obesity of the patient there could be no definite diagnosis made in this manner. It is safe to conclude that the pulsating mass is an abdominal aortic aneurysm until proved otherwise. However, in the absence of a palpable mass the differential diagnosis becomes more difficult.

4. *Femoral pulses.* The presence or absence of femoral pulses does not significantly aid in the diagnosis. In all our cases, some degree of femoral pulsation was obtainable. A week pulse could possibly be due to the state of shock at the time of the examination. The absence of femoral pulses does not in any way support the diagnosis of a ruptured abdominal aneurysm. It is wise, however, to note the presence or absence of the pulsations because this will aid greatly in post-operative evaluation of the functional state of the graft. It is important to note at the conclusion of surgery what pulsations are present or absent because only in this way can proper evaluation be made.

Pain—either abdominal or back pain, associated with shock or history of syncope plus a palpable abdominal mass—makes the diagnosis of ruptured abdominal aortic aneurysm a relatively simple one. The presence of pain plus shock in the absence of a palpable mass makes the diagnosis somewhat more difficult. In this instance, a flat plate of the abdomen might outline an arteriosclerotic abdominal aneurysm. Then the diagnosis, once again, becomes relatively simple.

Transporting a patient who has had an episode of syncope can be a dangerous step. However, if precautions are taken to enable one to combat any episode of shock during transportation, the information gained from such a diagnostic maneuver could very well prevent unnecessary exploratory laporotomy in a patient who is not a good operative risk. Further diagnostic x-ray evaluation, such as

barium enema or gastro-intestinal series, should be postponed if there is any possibility of a ruptured abdominal aortic aneurysm. The added stress of position-changing during the added x-ray studies might be enough to push the patient over the brink.

In our series, pre-operative diagnosis was correctly made in ten of these cases. Differential diagnosis between a ruptured aneurysm and a renal problem (such as nephritis or renal calculus) can be difficult. In addition, intestinal obstruction or diverticulitis are frequently confused with the true diagnosis. The story of shock with possible associated vomiting and upper abdominal pain may well be confused with coronary occlusion. Many times, electrocardiogram will show definite cardiac abnormalities. This is understandable in view of the age group with which we are dealing and also in view of the marked arteriosclerosis present in practically all of these patients. Most of them are hypertensive, most of them suffer from hypertensive cardiovascular disease with associated anginal syndrome, and a number have histories of past coronaries, possible cerebral vascular accidents and vascular occlusions of other sorts.

There is no place in the diagnostic work-up of a ruptured aneurysm for aortography. In elective situations where there is some question of a possible mass, an aortogram definitely is indicated. However, in the patient in distress with pain and a history of shock, there can be no need for aortography.

Treatment

Once the diagnosis has been made, treatment must be rapid and complete. The operating room must quickly be readied. Two venous channels with large bore cathethers should immediately be obtained in order to aid the rapid administration of whole blood. While awaiting the typing and cross matching, it is imperative to try and maintain a blood pressure. Therefore, vasopressor drugs may be used. At least six units of whole blood should be obtained. As soon as the first one is ready, whole blood should be administered. This should be done by actually pumping in the blood so that, as quickly as possible, the patient's blood pressure can be returned to a normal level. Prolonged periods of shock bring with them renal failure and cardiac failure. Despite the pumping of blood, the pressure may not be adequate. It is imperative, however, that the patient be transported directly to the operating room and the aorta be cross-clamped as rapidly as possible. Once the patient is in the operating room, while anesthesia is being administered a Foley cathether should be inserted into the bladder to empty it and facilitate surgical exposure. In addition, one can then note the amount of urinary output from the time of surgery. A Levine tube into the stomach is not essential, but if at all possible, it should be passed. The Levine tube should be passed after the patient has been anesthetized, as the retching and straining in the passage of the tube is likely to make the situation worse than it already is.

After the patient is anesthetized and the Foley cathether is in place, and once the blood is being pumped as rapidly as possible, surgical exploration should be carried out with a left paramedian incision extending from the costal margin down to Poupart's ligament. No time should be lost to clamp skin bleeders and muscle bleeders, as this can be done in the closing of the patient. To facilitate exposure, rapid eviseration of the patient should be carried out and the posterior peritoneum immediately incised. At this point the usual field is that of old and fresh blood in the retroperitoneal space, with perhaps some in the free peritoneal cavity. The aneurysm will be readily palpable in addition to the surrounding clotted blood. It is necessary to feel for the vertebrae and the pulsating neck of the aneurysm, being careful—if possible—to avoid the vena cava which is on the right lateral border of the aorta. Without further dissection, a clamp should be placed across the aorta. This may not be in as good a position as the operator desires. Therefore, once the aorta is clamped, further dissection can be carried out under better conditions and another clamp can be re-applied in a more suitable area. The left renal vein, which is usually a landmark for the neck of the aneurysm,

may not be discernible due to the clotted blood in the field. However, after adequate exposure the vein will readily be recognized. Resection of the aneurysm should then be carried out in the usual manner. Protection of the extremities should be carried out by injection of a one per cent heparin solution into each of the common iliac arteries before they are cross-clamped. The aneurysm should be removed completely, and a Teflon or Dacron graft can then be inserted. At the completion of the proximal anastomosis and one distal anastomosis, the proximal clamp should be removed and blood allowed to pass into the extremity which has already been anastomosed. Flush the graft after the proximal clamp is removed so that whatever foreign bodies might be within the neck of the aneurysm after it has been resected will be adequately flushed out the open limb of the graft. The second anastomosis is then carried out and after adequate hemostasis is obtained, the posterior peritoneum, or what remains of it, should be approximated as well as possible in an effort to keep bowel from actually coming in contact with the graft material itself. Numerous cases of fistula occurring between the graft and bowel, especially in the region of the duodenum, have been reported, and it is imperative that the peritoneum be interposed between the bowel and the graft. Anticipate the drop in blood pressure which will occur once the proximal clamp is removed. This can be done by being sure that blood is available and flowing when the clamp is removed. If necessary to administer blood under pressure, this should be immediately carried out.

Discussion

We advocate gastrostomy (Stamm type) for drainage purposes postoperatively. In this way, an indwelling stomach tube can be avoided. Most of these patients have ileus for three to four days, and we have found that respiratory complications have been virtually non-existent by using this method of stomach drainage.

We do not advocate drainage of the retroperitoneal space unless there is a copious amount of oozing. We do advise retention sutures. The technic includes wire closure of the anterior rectus sheath.

Rapid proximal control of the aorta is essential if survival is to be possible. Whether the neck of the aneurysm is below the renals cannot always be ascertained immediately in view of the blood in the operative field. Since most aneurysms start just below the renals, we must assume that this is the case and proceed with cross clamping the neck of the aneurysm. Once this is done, then an attempt should be made to dissect out the area to define the origin of the aneurysm.

A method of proximal control which we do *not* advocate involves cross clamping the aorta above the diaphragm. This adds two severe hazards which can be avoided in experienced hands. The added thoracotomy, no matter how limited, and the clamp above the renals, no matter how brief, will provide added needless hazards to an already desperate situation. Needless to say, a rapid resection of the aneurysm and replacement of the graft will decrease the likelihood of the patient's developing further complications. In our hands, average operating time from start to finish has been approximately 2½ hours.

In reviewing our statistics—seven survivors in sixteen cases—we were particularly interested in the amount of time it took from diagnosis to actual surgery. In cases 1, 5, 15 and 16, only a few hours lapsed between the onset of symptoms and the actual surgery. Despite the fact that the other three survivors had a number of days between the onset of symptoms and surgery, we feel that rapid diagnosis and treatment will definitely aid in the increased ratio of survival in these patients.

Conclusion

A patient with a ruptured abdominal aneurysm need not necessarily expire. Prompt diagnosis and rapid treatment in the manner above described should markedly increase the incidence of survival. Any patient with a history of syncope or shock in the presence of abdominal or back pain (with or without a

palpable mass) must be considered a possible ruptured aneurysm. All diagnostic steps must be taken to rule out other possibilities; and rapid treatment carried out. Aortography is contra-indicated if the diagnosis of ruptured aneurysm is considered.

Summary

The authors have reviewed their experience with ruptured abdominal aneurysms from 1960 to 1964. During that time, sixteen cases of ruptured aneurysms were resected with a survival of 7 of these cases (survival rate was 44 per cent). The diagnosis and treatment of this type of problem have been discussed. A plea has been registered for early diagnosis and rapid treatment.

Addendum: Since this paper was submitted for publication, an additional three cases of ruptured aneurysm have been operated with one survivor.

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377 Roseville Avenue (Dr. Gerard)

Excess Deaths Due to Cigarets Estimated at 250,000 Per Year

An estimate of the excess mortality due to cigaret smoking in the United States was computed from data of previous studies.

As shown by Hammond, among 36,975 male non-smokers and 36,975 men who smoked at least 20 cigarets a day (matched for age, height, occupation, etc.) excess deaths due to various causes related to smoking including lung and other cancers, coronary and other vascular diseases totaled 723. All lung cancer deaths totaled 122, which amounts to one-sixth of the excess deaths. The author estimates the total deaths due to cigaret smoking in 1962 as a quarter million, or six times the 41,376 lung cancer mortality. This amounts to about 14 per cent of all deaths that year.

The author states, "Cigaret disease is now the foremost preventable cause of death in the United States. Tobacco is an environmental hazard equal to all other hazards to life combined." Ravenholt, R. in *American Journal of Public Health,* 54:1923 (1964)

Hospital-MD Understanding

Many medical students lack factual knowledge of hospital administration simply because the subject has never been presented to them. The extreme but essential difference between the "responsibility for patient care" in which the public claims rightful participation and the "practice of medicine" which is purely a physician's prerogative is poorly understood. Considerable confusion and misunderstanding exists. Students do not comprehend the basic function of administration and do not recognize the need for a single directing hand in every institutional situation. Medical students have strong resistance to lay authority. The author asserts that they can acquire a better understanding of what responsible hospital administration means by class sessions, reading packets, exposure during clinical courses, and regular teaching rounds.

—R. R. Cadmus, *Hospitals* 39:49 (Jan. 1965)

STATE ACTIVITIES

Trustees' Minutes

April 11, 1965

A meeting of the Board of Trustees was held on April 11. For your further information, detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

New Jersey Academy of Medicine . . . Designated incoming President John Bedrick to serve in an advisory capacity to the Academy Board.

Cancer Detection Campaign . . . Endorsed the program in Bergen County to detect uterine and cervical cancer in women through the Papanicolaou smear test.

Civil Defense Emergency Hospitals . . . Approved the recommendations of the Disaster Medical Care Committee as follows:

1. That MSNJ urge that the packing cases containing the 1962 model civil defense emergency hospitals be functionally marked so as to indicate to which department of the hospital the case should be delivered.

2. That MSNJ urge its component societies to procure and assign physicians to staff the pre-positioned civil defense emergency hospital units in their counties; and that this be done in cooperation with the established hospitals of the community to insure that the staffing of civil defense emergency hospital units will not disturb the disaster plans of those established hospitals.

3. That MSNJ recommend to the State Director of Civil Defense Disaster Control that he notify the county coordinators to up-date their medical listing of all professional medical and allied medical personnel.

Air Pollution . . .

1. Voted to co-sponsor in 1966—in cooperation with the State Department of Health, the New Jersey Allergy Society, and the New Jersey Chapter of the American College of Chest Physicians—a Second Air Pollution Conference for Physicians.

2. Approved the recommendations of the Subcommittee on Air Pollution that the following program for county committees be carried out:

a. A letter be sent to the U.S. Public Health Service requesting that current publications on air pollution be sent to the chairman of each county committee;

b. The chairman of each county committee make himself known to the local Health Officers and become acquainted with the air pollution problems existing in each county;

c. Each county society conduct a Forum on Air Pollution with the citizens of the county, members of the Air Pollution Committee, allied scientists and the local newspaper. This has been done effectively in the past by county medical societies, enlightening the public in many medical and surgical fields.

Child Health . . . Agreed that closer liaison be established between the Society's Child Health Committee and the Coordinator of Accident Prevention of the State Department of Health.

Privileged Communication . . . Referred to the Council on Legislation the recommendation of the Mental Health Committee that legislation be introduced in New Jersey to grant privileged communication between all physicians and their patients in New Jersey.

Psychiatry and the Medical Profession . . . Referred to the Publication Committee the recommendation of the Mental Health Committee that articles on mental health and illness be carried in THE JOURNAL, to fill the obvious need for more educational programs for physicians in the profession dealing with psychiatry.

Mental Health Centers . . . Disapproved the recommendation of the Mental Health Committee that MSNJ support in principle the concept of federal subsidy to community mental health centers on a sliding scale. (The AMA has limited its approval to the one-time Federal grants—"bricks and mortar.")

"Little Orphan Annie" . . . Urged that, through THE JOURNAL, the attention of

the membership be brought to "false and misleading information as contained in the popular cartoon *Little Orphan Annie* regarding the illegal incarceration and fearsome treatment in mental institutions."

1965-66 Budget . . . Approved the proposed total budget for 1965-66 of $253,623.

Special Assessment . . . Approved the recommendation of the Finance and Budget Committee that the House of Delegates vote a special *per capita* assessment of $5 as a contribution to the Medical Student Loan Fund, to be available for loans in 1965 and 1966 (50%), to the bicentennial fund (25%), and to the Library of the Academy of Medicine of New Jersey (25%); and that the special *per capita* assessment apply equally to all dues-paying members. (This special assessment should be in addition to, and not part of, the budgetary assessment, with both being paid at the same time.)

1966 Dues . . . Adopted—at the recommendation of the Finance and Budget Committee—the 1966 per capita assessment at $40.

AMA-ERF . . . Received from AMA-ERF for presentation to the Dean of the New Jersey College of Medicine and Dentistry a check in the amount of $3,922.58.

Survey of Medical Conditions . . . Voted to cooperate with the State Health Department in a survey of attitudes and opinions of private physicians toward medical conditions which have serious social and community impact, emphasizing some communicable diseases, some legalistic problems, and problems relating to state and local health practices.

MAA Program . . . Authorized the Committee on the Chronically Ill and the Aging to meet with the Director of the Division of Public Welfare of the State Department of Institutions and Agencies, to effect changes in the current MAA Program.

Payment of Interns and Residents . . . Voted to introduce a resolution in the June 1965 AMA meeting opposing the payment of interns and residents by Blue Shield Plans.

Handicapped Award . . . Directed that, at the first session of the 1965 House of Delegates, Dr. Sol Parent of Newark be formally presented with his citation for meritorious service, in conjunction with the 1964 Physician's Award from the President's Committee on Employment of the Handicapped.

Address of Retiring President*

Charles H. Calvin, M.D.

Of my presidential responsibilities there remains for me but the obligation to take my leave. Time has swiftly sped since I entered upon this highest office in your power to bestow, and now I must bring my term of office to its close. In doing so, I have certain commitments in justice to fulfill.

First, I wish to extend to all who assisted me in my efforts in behalf of our beloved Society, my appreciation for the inspiration and help that they so uniformly afforded me. To my fellow officers, the members of the Board of Trustees, the chairmen of our councils and committees, and the members of our loyal and efficient staff, I give my heartfelt thanks. Constant and full cooperation characterized our work throughout the year—a cooperation which lightened individual burdens and safeguarded the decisions which we took. It is easy to be the leader of a group so understanding, so able, and so generously willing.

I also want to thank the officers and members of the component societies for their many kindnesses to my wife and me in connection

* Remarks before House of Delegates, third session, May 18, 1965.

with my official visits to their local gatherings. Wherever we went we were the recipients of distinguished courtesies and manifestations of hospitality and friendliness which we shall always delight to remember.

To the officers and members of the Woman's Auxiliary I likewise extend a deeply sincere word of commendation and congratulation for the many fine projects and programs which they regularly carry through, and for the eager willingness with which they are always ready to respond to any call from the Medical Society for special and frequently burdensome activity. In the areas of legislative concern and of public relations contacts, the Woman's Auxiliary is an indispensable part of our Medical Society team.

Finally my thanks are due, and are hereby tendered, to the members of this House of Delegates and to all our members everywhere.

It is essentially the function of the president of this Society to be the voice which utters the policy statements and official pronouncements which by democratic processes have been arrived at. In the elaboration of all such official decisions each member has the right and the duty to contribute whatever of a constructive nature he can supply. Together we are working for the preservation and perfection of the profession of medicine in this State to the end that we may better serve the total, genuine welfare of the people. I urge upon each member the necessity for his personal involvement and participation in the goals and activities of our Society. It will be a better and stronger Society inasmuch as each of us individually does all that he or she can to protect it from error and to insure that all that it commits itself to is consonant with human justice, dignity, and charity.

You have honored me greatly by having had me as your president. I have tried to serve in that capacity to the best of my abilities. I hope you have been pleased.

1965 Golden Merit Award

Following are the remarks of retiring President Charles H. Calvin on the occasion of the Ninth Annual Bestowal of the Golden Merit Award at the 199th Annual Meeting of The Medical Society of New Jersey on May 15, 1965.

This is the hour in which recognition is given for a lifetime of devotion and service. No more significant action will be taken at this, the 199th Annual Meeting of The Medical Society of New Jersey, than the conferral this afternoon of Golden Merit Award citations on the members of our Society who have served as doctors of medicine for fifty golden years.

It is my cherished privilege, as president of The Medical Society of New Jersey, to greet our jubilarians today and to convey to them the tribute of our love and of our thanks.

The good name of the profession of medicine, the achievements which have distinguished it, and the place of respect and honor which it holds in the minds and hearts of men and women everywhere have all been won for it by physicians of professional idealism and of loyal and dependable service such as those whom we honor today.

These are the scientists who mastered the knowledge that has meant life and health to their patients. These are the artists who with proficiency and distinction practiced the art of medicine. In short, ladies and gentlemen, these men and women—with others like them, wherever people turn to their physician as a friend in need—these are the profession of medicine incarnate. What honors medicine can claim, they have helped to earn for it. What triumphs it has enjoyed, they have helped to win.

Therefore, with full and grateful hearts, we hail you today, my colleagues. In token of our esteem and gratefulness we offer you the Golden Merit Award of The Medical Society of New Jersey as a deserved accolade for the

long and distinguished services which you have rendered to your fellowmen. In acknowledging your sacrifice, we want also to give formal recognition to the sacrifices of your spouses and families who, because of your gifts of heart and mind, shared you so generously with the people to whom you ministered.

You have enriched the world by your life and service, and you have in the process enriched yourselves through the wealth of love and respect which you have deservedly amassed. May the remaining years of life be abundantly sweet to you, and may you enjoy that sweetness for many tranquil, happy years.

RECIPIENTS OF THE GOLDEN MERIT AWARD

Atlantic County

Royal Elwood Durham, M.D., 112 South Oxford Avenue, Ventnor
Carl A. Surran, M.D., 2327 Mulbury Drive, Orlando, Florida

Bergen County

Taeke Bosch, M.D., 290 East Franklin Turnpike, Ho-Ho-Kus
Erwin W. Reid, M.D., 4557 Clinton Boulevard, Lake Worth, Florida

Burlington County

Thomas Johnson Summey, M.D., RFD #2, Box 236, Charlottesville, Virginia

Cumberland County

Vincent Giacalone, M.D., 1315 East Landis Avenue, Vineland

Essex County

Stephen Emery Burke, M.D., 212 First Avenue, Newark
Rita Sapiro Finkler, M.D., 26 Troy Drive, Short Hills
Ernest Gennell, M.D., 298 Parker Street, Newark
Roy Griffith, M.D., 263 Forest Avenue, Glen Ridge
Herman Samuel Nash, M.D., 320 South Harrison Street, East Orange
Jacob William Siegel, M.D., 96 South Tenth Street, Newark
Julius Sobin, M.D., 158 South Harrison Street, East Orange

Hudson County

John Joseph O'Connor, Sr., M.D., 2124 New York Avenue, Union City
Jacob Moses Stein, M.D., 68 Columbia Terrace, Weehawken

Mercer County

Samuel Blaugrund, M.D., 833 West State Street, Trenton
Richard Bilderback Ernest, M.D., 240 West State Street, Trenton
Benjamin Alfred Treiber, M.D., 1415 West State Street, Trenton

Middlesex County

Melvin Mundy Hunt, M.D., 140 Jackson Street, South River

Monmouth County

James Alfred Fisher, M.D., 601 Grand Avenue, Asbury Park
William Frederick Jamison, M.D., 606 Evergreen Avenue, Bradley Beach
James Wesley Parker, M.D., 175 Shrewsbury Avenue, Red Bank
Ernest Augustus Robinson, M.D., 149 Atkins Avenue, Asbury Park

Morris County

Raymond Hamilton Mathews, M.D., 44 Maple Avenue, Morristown

Passaic County

Leon Ephraim DeYoe, M.D., Old Mill Road, Franklin Lakes
Agustin Gallardo, M.D., 61 Lakeside Avenue, Pompton Lakes
Morris Joseph, M.D., 80 Passaic Avenue, Passaic
Nathan Philip Lobsenz, M.D., 294 Broadway, Paterson
Augustin Martin Schultz, M.D., 379 Union Avenue, Paterson
Fred Vosburgh, M.D., 663 Main Avenue, Passaic

Sussex County

George Francis Johnson, M.D., Mattison Avenue, Branchville

Union County

Maynard Gilmore Bensley, M.D., South Woodstock, Vermont
Harold Foote Johnson, M.D., 1010 Park Avenue, Plainfield
Irving Lerman, M.D., 1024 East Jersey Street, Elizabeth
Camella A. Losada, M.D., 70 Morningside Drive, New York, New York
Elsie McClintock, M.D., 1439 Maple Avenue, Hillside
Herbert Austin Vogel, M.D., 981 Townley Avenue, Union

Academy of Medicine Library Acquisitions

NURSING

Bullough, B. and Bullough, V. L. The emergence of modern nursing. N.Y., Macmillan, 1964 . . . Tudbury, M. A. Psychiatric nurse in the hospital. Springfield, Ill., C. C. Thomas, 1958 . . . Shafer, K. N., Sawyer, J. R., McCluskey, A. M. and Beck, E. L. Medical-surgical nursing. St. Louis, Mosby, 1961 . . . National Tuberculosis Assoc. Nursing Advisory Service and National League for Nursing. Safer ways in nursing to protect against airborne infections. N.Y., Nat. Tuberculosis Assoc., 1962.

NUTRITION

Goldblith, S. A. and Joslyn, M. A. Milestones in nutrition. Westport, Conn., Avi Publ. Co., 1964 . . . Schultz, H. W., ed. Symposium on foods: proteins and their reactions. Westport, Conn., Avi Publ. Co., 1964.

ANNOUNCEMENTS

Pharmacopeia XVII Now Available

The new edition of the *U.S. Pharmacopeia* will become effective September 1, 1965. It includes 156 newly recognized items. For the first time, the *Pharmacopeia* now classifies drugs by pharmacologic action and by pharmaceutic utility. This listing includes 165 headings and offers the practitioner a rich and rapid source of information. The law requires that the generic names used in the *Pharmacopeia* be included in all labeling, advertising, and promotional literature. The *Pharmacopeia* now includes a table showing the synonyms and other designations for the various drugs. This 1300 page volume is available at $12.50 postpaid from the Mack Publishing Company, Easton, Pennsylvania.

Poison Control Centers

For the small sum of 20 cents, you may get the brand new (June 1965) directory of poison control centers in the USA. Write to the Government Printing Office, Washington D.C., 20402 and ask for PHS Publication 1278, Directory of Poison Control Centers. This directory lists the address, telephone number, and personnel of poison control centers functioning in the four corners of the nation. The listing includes centers which provide round-the-clock information services for the medical profession concerning the prevention and treatment of accidents involving ingestion of poisonous and potentially poisonous substances.

Lead Poisoning Kits Now Available

You can readily obtain a "blood lead kit" to enable you to test for lead poisoning. You may get the kit by telephoning (area code 609) 292-5617 and asking for the Poison Control Office. In Camden, Newark, Trenton, Jersey City, and Paterson you can pick up a kit at the Department of Health, Mill Street, Paterson; or at the Department of Health, Plane and William Streets, Newark; or at Pediatrics Five-B, Jersey City Medical Center; or at the Bureau of Health, City Hall, East State Street, Trenton; or at the Department of Health, City Hall, Camden.

Commissioner Kandle has pointed out that, although cases of lead poisoning can occur in any municipality, they are most frequently found in the larger cities in houses that were painted with paint containing lead. Some children chew on window sills or eat paint flecks from the walls and thus absorb the lead.

Occupational Health Guide For Physicians Now Available

A new guide, "Personal Protective Equipment for Employees in Industry" has just been published by the AMA Council on Occupational Health. It covers an area not heretofore presented from the viewpoint of, and for the use of, the medical profession. It is for physicians who serve industry part-time or on-call; and will also be useful to practitioners to whom employees come for preplacement, periodic examinations, diagnosis, or treatment. It familiarizes the physician with the selection and use of clothing and devices needed to protect workers from hazards which may result in occupational illness or injury.

Individual copies of the guide may be obtained without charge from the AMA Department of Occupational Health, 535 North Dearborn Street, Chicago, Illinois 60610.

Life Insurance For Epileptics

According to a recent study by the Epilepsy Foundation, persons with epilepsy have trouble getting health and life insurance. This study indicates that most persons with epilepsy can now obtain some form of life insurance—though generally at higher rates. But for persons recently and severely afflicted with some

forms of epilepsy, it is almost impossible to obtain any form of life or health insurance.

Health insurance coverage available to some persons with epilepsy is a recent development, still in the experimental stages. As more experience data are collected, it will become easier for a person with epilepsy to obtain health insurance.

In the meantime, the Foundation is urging persons who can obtain group life or health insurance to do so, and to convert such coverage to individual plans in the event that they should terminate their group participation for any reason.

The Epilepsy Foundation is the largest voluntary agency concerned with the problems of America's two million persons with epilepsy. A pamphlet summarizing the Eilers-Malone Report is yours by writing to the Epilepsy Foundation at 1419 H Street N.W., Washington, D.C. 20005.

Journals For Overseas Colleagues

Physicians in New Jersey are being asked to send their medical journals—after they have read them—to colleagues overseas (Asia, Latin America, and Africa) who wish to have access to current medical literature but, either because of currency regulations or actual cost, cannot themselves subscribe. We can supply you with the name, address, and medical specialty of doctors in these areas who would be happy to receive these much wanted journals, *particularly specialty journals.*

This direct "Doctor-to-Doctor" program is being promoted by the United States Committee of The World Medical Association to help alleviate the lack of current medical publications and to further international good will. Your contact with these colleagues in other countries, we can assure you, will prove very gratifying. If you wish to participate, send your name, address, and titles of journals you will contribute to United States Committee, The World Medical Association, 10 Columbus Circle, New York 19, New York.

Health Movie Catalogue Now Available

You can, by return mail, get a catalogue of health films available on a rent-free (loan) basis to professional groups or to lay organizations under professional guidance. For your catalogue, write to Pharmaceutical Association at 1155 N. W. 15 Street, Washington, D.C. 20005 and ask for the "Catalogue of 184 motion pictures in the health field." These films do not promote particular products; are all 16 millimeter sound films; and cover the entire gamut of medical care from alcoholism through open heart surgery to urology.

Psychoanalytic Society Elects

The New Jersey Psychoanalytic Society announces the election of Dr. George Zavitzianos of Tenafly as the President for 1965-66. Dr. John E. Hughes of East Orange has been named as the State Society's delegate to the American Psychoanalytic Association; and Dr. Julius Kassen of Englewood, as Secretary.

Bela Schick Testimonial Book Published

The Waverly Press of Baltimore, Maryland, announces that, as a tribute to Bela Schick, they are publishing a volume called *Aphorisms and Facetiae of Bela Schick.* Written by Dr. I. J. Wolf of Paterson (a member of The Medical Society of New Jersey), the volume is packed with the wit and wisdom of this dean of American pediatrics. The volume is available gratis to our readers through the courtesy of Knoll Pharmaceutical Company, Orange, New Jersey.

Postgraduate Courses At Vienna, Austria

The American Medical Society of Vienna, in connection with the Vienna Academy of Medicine, offers a diversified program of graduate seminars at the University Clinics of Vienna during 1965, as reported by Dr. M. A. Kline, Executive Secretary of the organization. These seminars, conducted for English speaking visiting doctors at any time in all specialties and subspecialties, are for any duration—from a few days to several months. Practical sessions, patient examination and treatment, surgical operations, round table

discussions, and grand rounds are part of these seminars. Further information may be obtained by writing to the Executive Secretary, American Medical Society of Vienna, Universitaetstrasse II—Vienna I, Austria.

Fellowship in Medical Science

A $7,500 fellowship awaits the winner of the Glorney-Raisbeck award. This is a renewable one-year grant for study or research in any medical field. The applicant must obtain affiliation with an institution which will facilitate his studies. Applications should be directed to Committee on Medical Education, Academy of Medicine, 2 East 103 Street, New York, N.Y. 10029. Deadline for filing is October 31, 1965.

Erratum

In Dr. Mervin Fischman's article on *Control of Obesity in Children* in the January 1965 JOURNAL, the phrase "anterior-pituitary-line" should read: "anterior pituitary-like." Under table #5, the numberal −3.89 should read −4.75. The JOURNAL regrets this error.

LETTERS TO THE JOURNAL

More on Drug Labelling

Dear Sir:

In your April 1965 issue, on page 120, in the editorial, "Drug Names on the Rx Label," the second paragraph reads: "Name-labelling makes life easier for the pharmacist, but we see now that the *Professional Pharmacist* (highly respected nationwide journal of that profession) doesn't like the idea, either."

This would suggest that pharmacists, in general, approve of the concept of drug names on the prescription label. A careful review of pharmacists' discussions in the past three years would probably reveal that the reverse is true.

This has been the subject of considerable discussion at national conventions and at meetings of pharmacists. I have never left any of these meetings with the feeling that the consensus regarded this practice with anything but serious misgivings. Mr. Rubin is expressing the views of the majority of pharmacists.

It might be desirable for both the pharmaceutical and medical societies on the state and local level to meet jointly to consider this question of drug names on the prescription label.

Samuel Barden, Ph.G.
Ridgefield Park

Dear Sir,

Your editorial "Drug Names on the Rx Label" in the April issue interested me, since I started the practice 3 years ago and have labelled *all* my prescriptions—at least 10,000—since with no regrets and great convenience. I wrote a page to that effect which was published in the bulletin of the county medical society. Apparently, it affects the pharmacy profession that some of their medical omnipotent tradition is lost by so doing. However, when I make house calls and find a variety of other doctors' pills labelled only "one daily" or "one before meals," it overshadows all other considerations in treating a seriously ill patient when the stores are closed. Despite all the fear psychology listed in the 6 reasons for not labelling, I belong to the courageous group who have tried it and will continue to enjoy the realistic daily benefit, while the others think up reasons for not doing so.

Isn't it really their pride which suffers most?

Morris Soled, M.D.
Jersey City

OBITUARIES

Dr. Benjamin L. Gordon

At the grand old age of 95, Dr. Benjamin Lee Gordon died on March 30, 1965—bringing to a close an unusual career of medical practice and historical expertise. Born in Lithuania in 1870, he came to the United States four years later. In 1896 he received his M.D. degree from the Jefferson Medical College. For the next five years he did general practice in Philadelphia and then gave that up to do graduate work in ophhalmology. He studied at the Wills Eye Hospital and in Vienna at the Allgemeine Krankenhause. In 1910 he toured the Near East and published one book and several articles on his observations. He was a founder of the Zionist Organization of America. In 1929 he was appointed to the Ophthalmic Clinic at the Graduate School of the University of Pennsylvania. The following year he moved to Atlantic City, where he set up his office for the private practice of ophthalmology. He served most of the hospitals in the shore area in various grades in ophthalmology. He saw active military service during the Spanish American War.

Dr. Gordon was an early diplomate of the American Board of Ophthalmology. He was a contributor to the *Encyclopedia Brittanics* and the author of five books including the well-known "Romance of Medicine" and "Medicine in Antiquity" (Davis publications).

Dr. James M. Murphy

Born in Troy, New York, in 1887, Dr. James M. Murphy died at the Pollak Hospital in Jersey City on April 7, 1965. His wife had died only 48 hours earlier. Dr. Murphy had received his M.D. at Queens College in Canada in 1921; and after interning there, he came to New Jersey in 1922 to set up private practice in Hudson County. He was a general practitioner, affiliated with the staff of St. Francis Hospital in Jersey City. He was active in committee work in the Hudson County Medical Society in the 1930's.

Dr. Arthur W. Pindar

An automobile accident on April 6 brought to an abrupt close the useful life of Dr. Arthur W. Pindar. Dr. Pindar received his M.D. at Cincinnati Medical School in 1925. After interning in Ohio, he came to Hudson County, where he was born. He practiced later in Teaneck and was active in Rotary Club affairs there. Dr. Pindar was associated with Christ Hospital in Jersey City, St. Mary's Hospital in Hoboken, and Holy Name Hospital in Teaneck. He held many offices in the Bergen County Chapter of the American Academy of General Practice and left private practice only a few years ago to serve as admitting officer of the Veteran's Hospital at Clarksburg, West Virginia. Dr. Pindar was 65 years old at the time of his death.

Dr. Edward Salmon

Dr. Edward Salmon of Jersey City died on April 6, 1965 at the tragically early age of 58. Born in Jersey City, he received his baccalaureate degree at Fordham in 1928 and his M.D. at Georgetown in 1932. He was a general practitioner, interested and skilled in pediatrics, child guidance, and psychiatry; and served for many years as a member and officer of the Hudson County Mental Health Board. He also had a decade of duty as the New York Area medical director of Swift and Company, and in 1958 became director of the Hudson County Mental Health Clinic. He was also on the staff of St. Francis Hospital in Jersey City.

Dr. Barney Schaffer

On March 7, 1965, Dr. Barney Schaffer, well known Essex County general practitioner, died after a long illness. Born in Newark in 1907, he earned his baccalaureate degree at the University of Alabama in 1930 and his M.D. at Michigan in 1934. During World War II, he was on active military service in the medical corps of the Army of the United States. He was affiliated with the Clara Maas, the American Legion, the East Orange General, and the Presbyterian Hospital in Newark. Dr. Schaffer could never be lured away from family practice which he considered the highest form of the medical art.

BOOK REVIEWS

Current Therapy 1964. Edited by Howard F. Conn, M.D. Philadelphia, 1964, Saunders. Pp. 797. ($13.00)

In general, this book deals with therapy. Many sections, however, are prefaced by a few words on etiology and clinical characteristics. References are lacking, though three or four well chosen ones on each topic would have broadened the reader's perspective, without appreciably lengthening the book. Most of the contributors take a therapeutically conservative attitude. It should be reassuring to the practitioner (overwhelmed by the recommendations of the pharmaceutical houses and women's magazines) to know that the treatment of most conditions does not change much from year to year. This is not to imply that the book is not up to date, for discussions of topics such as the newer penicillins are remarkably current. Some attempts to be up to date go astray. Angiotensin II (Hypertensin) is noted to be "at least as effective as norepinephrine" for cardiogenic shock although it is specifically *not* recommended for this purpose by the manufacturer and may be harmful. An occasional contributor recommends therapy such as chloroquine for infectious mononucleosis and corticosteroids for heart block in myocardial infarction that have not been proved effective. A urologist advises catheterization to obtain a urine specimen. A surgeon implies that surgery is preferred over I^{131} in most cases of hyperthyroidism, even in older people as long as their hearts can stand climbing up on the operating table. An internist (or even a more rational surgeon) would probably disagree. Endometriosis is the only controversial topic discussed by two authors with conflicting views. Other topics would benefit from similar treatment.

By comparison, for instance, with the treatment sections of the *Cecil-Loeb Textbook of Medicine,* the book under review is a little more wordy, sometimes a little more up to date, but seems to me to be less reliable. For the busy practitioner with older textbooks, this book covers many fields adequately. For students and house staff, a recent text provides a better review and, generally, a comparable summary of treatment.

LONNIE B. HANAUER, M.D.

Surgical Pathology. L. V. Ackerman, M.D. and H. R. Butcher, M.D. St. Louis, 1964, Mosby. Ed. 3. Pp. 1244 with 1216 illustrations. ($18.75)

If the surgeon is ever to be more than a skilled craftsman, it is through his understanding of surgical pathology. The standard texts of pathology are essentially studies based on dead tissue. Here, however, is a standard text of the pathology of the living. While microscopic (and even electromicroscopic) material is not neglected, the emphasis is, as it should be, on gross pathology. This is a magnificent volume, profusely illustrated, covering every part of the body accessible to the surgeon's knife. The good surgeon should know the kinds of details here described and pictured. It makes one, indeed, proud of modern surgery to realize how important, how solid, and how formidable is the background of surgical knowledge.

VICTOR HUBERMAN, M.D.

The Specialties in General Practice. Edited by Russell L. Cecil, M.D. and Howard F. Conn, M.D. Ed. 3. Philadelphia, 1964, Saunders. Pp. 676, illustrated. ($17.50)

This well-written book is primarily one for the general practitioner. The printing and illustrations are excellent. The style is good and the text is easily readable. It is a history of specialties in general practice. The contributors discuss technics and improvisations in the management of problems as they arose. Its coverage is quite complete. The authors and the contributors are well qualified specialists. Each specialty has assembled and organized information from many sources to provide an up-to-date work and goes far to answer most of the questions the doctor would like to have answered. It offers helpful information for the general practitioner in his role of professional management and guidance of his patients, allowing him to know what he can correctly do and yet recognize his limitations. This volume is arranged in such a manner as to make it an outstanding reference work, and it will be a valuable guide in planning and carrying through the recommended therapy. I believe it should form a part of the average general practitioner's library.

C. H. CALVIN, M.D.

Case Studies in Obstetrics and Gynecology. F. Jackson Stoddard, M.D. Philadelphia, 1964, Saunders. Pp. 312. ($8.50)

This book crams a tremendous amount of obstetrics and gynecology into a relatively small space. The author has achieved this through the question and answer method thus eliminating much of the repetitious and sometimes useless verbiage found in textbooks and articles. He has managed to cover the field of obstetrics and gynecology very well ranging from the "A" of amenorrhea to the "V" of vaginitis and including the entire alphabet in between. There are medical and surgical complications as well as pure obstetrical and gynecologic problems. This book, having been written by one man, necessarily reflects his opinion alone. An example of this is the brusque way in which chemotherapy is dismissed in the treatment of genital cancer.

JAMES F. FLANAGAN, M.D.

The Specificity of Serologic Reactions. Karl Landsteiner, M.D. 2nd Edition. New York, 1963, Dover Publications, Inc. Pp. 330 ($2.00)

This revision of the Harvard Press edition is highlighted by a new preface, an exhaustive bibliography of the contributions of the author, and a significant chapter on molecular structure. These changes are in no small degree due to the cooperation of Drs. M. Chase and A. Wiener, long associates of Dr. Landsteiner.

While the revised edition *per se* adds little of significance to this monumental work, the complete bibliography is an indispensible reference list to any basic immunologic investigator. Of greatest significance is the chapter by Dr. Linus Pauling. One is repeatedly impressed in reviewing the works of Dr. Landsteiner by his indefatigable search for a basis for the specificity of biologic units and the attraction of specific substances to each other. In his incomparably simple manner, Dr. Pauling has applied our present principles of molecular biology, to which he has contributed so much, to the solution of many of these questions.

LESTER M. GOLDMAN, M.D.

Drugs of Choice, 1964-65. Edited by Walter Modell, M.D. St. Louis, 1964, Mosby. Pp. 1018 with 45 tables. ($16.75)

Since 1958, this biennial volume has been a welcome spring visitor. It is an intensely practical compendium, telling the reader what drugs are available for what syndromes; explaining dosage, contra-indications, and precautions. There is enough academic material to take the book out of the oversimplified "outline" class, but not so much as to clutter the text with theoretical considerations. Bound into the book is a unique, green-colored, 130 page drug index which lists the medications alphabetically (both trade and generic names are given) and gives capsular information on each. Tabulations (as, for example, a listing of adrenergic agents) are especially handy. Forty-seven experienced clinicians are listed in the contributors' column. The arrangement of chapters is logical, and an exceptionally detailed index makes the book an easy one for ready reference. *Drugs of Choice* will soon earn an honored place on any practitioner's book-shelf or desk.

Ulysses S. Frank, M.D.

Electrocardiographic Notebook. M. Irene Ferrer, M.D. Ed. 2. New York, 1964, Harper & Row. Pp. 112. Illustrated. ($2.75)

This summary of electrocardiography is a paperback. It begins with anatomic considerations of electrical conductivity in the heart muscle and then relates these to the sequence of electrical events which make themselves evident in the electrocardiogram. The author, quite properly for an elementary text, devotes the first half of the book to developing the norm. He includes some practical hints which are usually learned only after years of experience. The second half of the book is devoted to succinct descriptions of abnormalities. These are adequate in spite of their brevity, but for some reason, Dr. Ferrer devotes 6 full pages to the rather rare Wolf-Parkinson-White Syndrome.

Figures and tables are placed in the back of the book, and illustrative electrocardiograms follow these. Not a single electrocardiogram is included in the body of the text. There are only references by number to those in the addendum. This unusual arrangement seems unsuitable in an elementary book. However, since *Electrocardiographic Notebook* pretends to be no more than just that, it is amazingly complete considering its brevity.

Harvey E. Nussbaum, M.D.

Diet and Bodily Constitution. Edited by G. E. W. Wolstenholme, M.A. and Maeve O'Connor, B.A. Boston, 1964, Little, Brown and Company. Pp. 120 ($2.95)

This small book is interesting and stimulating; but it is not easy reading. It consists of papers read by some of the leading researchers in the field of nutrition and biochemistry. The text shows how difficult it is to study the constitution of the rat and how much more difficult it is to apply the conclusions in studying the constitution in man.

In studying the human being—his height, weight, age, the state of his liver, his resistance to disease, mental capacity, place in society, and his cultural habitat in the world around him—the contributors have tried to study his constitution. They tried to determine if these attributes are affected by diet in the early years of life or even by diets in the later years of life. The practitioner may find it dull reading; but for the one who has more than a casual interest in nutrition, it is as thrilling as any detective mystery novel.

S. William Kalb, M.D.

Directory of Resources for Mentally Ill Children in the United States. National Association for Mental Health, Maryland, 1964, U. S. Department of Health, Education, and Welfare. Pp. 93. ($2.00)

The foreword to this directory states that, "The information, so sorely needed, has not heretofore been compiled."

The last sentence contains both explanation and apology relative to the limitations of this first issue. Directories must be concise; but if they are to be useful, the conciseness must be limited optimally in terms of the primary objective of the publication. Further, the information must be clearly stated, accurate, and current. Ambiguities of terminology must be replaced by clear definition of terms. Thus the term "residential" used in this directory may lead to confusion, as it includes "in-patient" services. Bellevue Hospital, for example, is listed as a residential placement. Is this properly so? On the other hand, Mt. Sinai Hospital, which *does* have an in-patient children's service for the mentally-ill, is not so listed. This would suggest that other in-patient children's services in the United States may have been overlooked. In New Jersey, a number of omissions were noted, such as the Diagnostic Center at Menlo Park, Bonnie Brae Farms, Janet Memorial Home, and others. Further, the material on the Arthur Brisbane Child Treatment Center and the New Jersey Neuropsychiatric Institute included information which led to inaccurate impressions as to what services are available and what intake policies actually do exist.

This issue of the Directory is a beginning. If it cannot be developed into the detailed manual that is needed, it would best be abandoned and left to other resources to develop.

Arnold M. Kallen, M.D.

Cancer of the Stomach. William H. ReMine, M.D., James T. Priestley, M.D., Joseph Berkson, M.D., and Members of the Staff of the Mayo Clinic. Philadelphia, 1964, Saunders. Pp. 255, illustrated. ($11.50)

The authors agree that cancer of the stomach, its detection and treatment, remains about the same problem it was when a similar study appeared from the Mayo Foundation some years ago. However, this is again an exhaustive analysis of the subject. The text indicates that, as yet, surgery is the only definitive, if any, type of treatment. The book includes four chapters dealing with diagnostic technics and criteria regarding gastric cancer, including cytology, acidity, tetracycline fluorescence, and autoradiography.

There is an important chapter on the decision regarding operation. The purely surgical aspects of stomach cancer are now considered. These include separate chapters on anesthesia, partial gastrectomy, total gastrectomy, palliative surgery, and post-operative care. Special features are the excellent illustrations, many in color. These chapters are dotted with self-explanatory tables revealing the results of all these surgical efforts. The pathologic aspects of gastric malignancy are discussed with illustrations of gross specimens, along with their histology. Classifications of malignancy are also discussed.

The book ends with a survey of all aspects of the care of the patient with gastric malignancy, such as operative procedures with their survival rates, morbility, mortality and hospital stay. This survey covers a 52-year period. The book ends on a note of challenge in that we must still improve our diagnostic acumen and our overall therapy in this dread disease.

Andrew J. V. Klein, M.D.

Modern Treatment: March, 1964. Treatment of Pulmonary Diseases, Guest Editor, Carl Muschenheim, M.D. Treatment of Liver Disease, Guest Editor, Richard B. Capps, M.D. Pp. 293. New York, 1964, Hoeber. Soft cover. (Published bimonthly, $16.00 per year)

The discussion here is primarily that of medical treatment. Surgical treatment is alluded to only briefly. Each author contributes a chapter in his own field as well as a foreward to his symposium. An expert in each major subdivision then gives the details of a regimen of treatment. The lucid style is to be highly commended. Many phases are presented in a well rounded complete picture, usually unavailable in other textbooks, and certainly not under one cover.

The methods of treatment are the result of each author's individual experience. There may be areas now and then in which there would be a divergence from the author, but the overall recommendations do offer a clear and practical exposition that could be followed with assurance and profit, possibly modified to fit the individual case or circumstance. The book is a compendium of information on the diseases concerned. It is primarily a reference volume as well as a valuable guide.

An unexpected bonus in this work is the excellent set of summaries of the clinical and diagnostic features that proceed the details of treatment. This offers a painless, rapid review. A chapter on "Liver Function Tests" is included because the laboratory tests are essential for proper treatment.

Some parts of the book contain reference to pediatric dosages; some do not. Also, sometimes proprietary names of drugs are given; sometimes not. The book would have had even greater usefulness if pediatric as well as the adult doses of drugs had been included, as well as the proprietary and generic names of all recommended drugs.

The attractive paperback format accounts for its reasonable price. The soft cover also serves as a reminder that so rapid are the advances in therapeutics these days, that the present volume must necessarily be replaced in the next few years by a similar one that will make this edition appear antiquated. This thought of the evanescence of the authoritative concept of today is one that is somewhat depressing—or exhilarating—depending on one's viewpoint. SAUL LIEB, M.D.

Appraisal of Current Concepts in Anesthesiology. Edited by John Adriani, M.D. St. Louis, 1964, Mosby. Pp. 478. ($10.75)

This compact, fact-filled book is useful to every anesthesiologist and anesthetist. It presents, in a concise and systematic manner, all the pertinent details relating to a wide variety of up-to-date concepts and data in the specialty of anesthesiology.

Illustrative of a few of the appraisals made are those dealing with: (A) drugs, such as Angiotensin.® THAM,® rauwolfia alkaloids, methoxyflurane, adrenocorticosteroids and xenon; (B) clinical conditions, such as hyaline membrane disease, mongolism, porphyrias, hepatic coma and glaucoma; and (C) technic, such as hemodialysis and electric anesthesia.

The forty-five different subjects included have been prepared *by clinicians,* who culled the material from various journals and texts. The presentations, therefore, are primarily designed *for clinicians* rather than for research workers. JOSEPH ANTHONY COX, M.D.

†Deceased April 16, 1965.

The Cigarette Habit: An Easy Cure. Arthur H. Cain. New York, 1964, Doubleday. Pp. 106. ($.95)

"The United States Public Health Service, in their recently published brochure, has declared that cigarette smoking can cause any number of diseases and had advised the cessation of the use of tobacco in any form, and the sensible thing to do is to stop smoking." The habit, especially with cigarettes, is a difficult thing to break. Any information on how to stop the use of tobacco is a very welcome contribution. The present handbook "The Cigarette Habit: An Easy Cure" was originally published by Arthur King, under his pen name in 1959.

His system for breaking the habit has now been in use for over ten years. He provides a day-by-day, step-by-step procedure how to stop smoking without gaining weight, and without the usual withdrawel symptoms. As a special feature this volume also contains "Highlights" from *Smoking and Health,* the official report of the advisory committee to the Surgeon General.

Arthur H. Cain is a psychologist who was himself a two-pack-a-day smoker for twenty years and who cured himself (as well as thousands of others who had previously been unable to stop smoking), using the technics presented here.

Having personally encountered the difficulties of getting patients to stop the tobacco habit over a number of years, I welcome this handbook as a therapy aid.
JACOB SCHMUKLER, M.D.†

Marriage Counseling in Medical Practice. Edited by Ethel M. Nash, M.A., Lucie Jessner, M.D. and D. Wilfred Abse, M.D. North Carolina, 1964, University of North Carolina Press. Pp. 368. ($8.00)

This book amplifies the theme of marital counseling in medical practice and points up the need for greater preparation and study of the physician in this significant area of human activity. A valuable compendium of practical and theoretical experience, it offers a significant help to the practicing physician. It is replete with rich examples in the practice of the generalist, the obstetrician, and the pediatrician. The section on premarital medical counseling is especially meritorious. The authors mention the character and deficiencies of knowledge of sex and human relationships in medical students and general gaps in medical education which ill prepare the future physician for his role as counselor to the troubled. A few universities do try to correct this omission.

Although there are some excellent discussions of the practice of marital counseling, this book (as in so many do-it-yourselfs) fails to clarify the true role of the physician in marital and other counseling. The psychiatric articles do not amplify this. Indeed, one is left with the notion that what one cannot handle should be sent to the marriage counselor. The handling of marital conflict by the ancillary professional leaves much to be desired, as evidenced by one author's statement that "the incompetents and quacks outnumber the dedicated, competent professionals in the field." And even among the competents, many are treating neurotic reactions entirely beyond the scope of the marital problem with neglect of genuine medical collaboration. Altogether this volume is well worth reading and thoroughly informative, but it points up the need that reading is not enough and that it behooves all physicians to inform themselves through courses and practical experience in the most universal of mankind's relations, marital interaction. J. LLOYD MORROW, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

June, 1965 • Vol. XXXVIII, No. 6

DIAGNOSIS AND TREATMENT OF BACTERIAL PNEUMONIAS

Despite antimicrobials effective against almost all pulmonary pathogens, bacterial pneumonia has a high morbidity and mortality. Complications and problems of treatment are discussed.

Infections of the lung have come to be considered examples of diseases conquered by chemotherapy. There is no doubt that antibiotics have exerted a dramatic effect on the course and outcome of bacterial pneumonias, but this group of diseases continues to rank high as a major cause of morbidity and death. This is related in part to the changing ecology of these infections which were formerly common among young relatively healthy individuals, but are now found primarily among aged, debilitated patients with chronic disease.

Furthermore, antibiotics themselves contributed to the change in the clinical picture of pneumonia and have created problems in their use. Some of the features which have come to life regarding the diagnosis, course, and treatment of bacterial pneumonias are the following:

(1) The etiologic agent frequently is missed on Gram smears of sputum; (2) the appropriate organism is not suspected; (3) there is delay in recognizing superinfection; (4) the systemic complications, particularly meningitis, are overlooked; (5) antibiotics are not properly used; (6) alterations in flora of the sputum in patients receiving antibiotics are not appreciated; and (7) the propensity of nonbacterial complications of pneumonia to produce fever is not well known. These problems will be discussed.

Staphylococcal Pneumonia

Staphylococcal pneumonia may occur under a variety of circumstances such as a sequel to viral influenza, a manifestation of hematogenous staphylococcal disease, and a complication of structural disease of the lung.

Pneumonia associated with influenza occurs in individuals of all age groups, but patients with pregnancy, valvular heart disease, and chronic lung disease appear to be particularly prone to development of this fulminating infection. The clinical picture is abrupt in onset, progresses rapidly with marked dyspnea, cyanosis, scant and bloody sputum, and evidence of alveolar-capillary block. The virus may be more important than the staphylococcus, but treatment with penicillinase-resistant penicillins is imperative.

Hematogenously disseminated staphylococcal infection has been noted frequently among narcotic addicts with septic thrombophlebitis. Patients suspected of having staphylococcal disease should be treated with penicillinase-resistant penicillins until results of cultures and sensitivities are available. If the organism is sensitive to penicillin G, therapy should be changed to this drug.

Certain X-ray findings should raise the suspicion of staphylococcal disease. These include the development of pneumatocoeles, the occurrence of spontaneous pneumothorax; rapidly changing infiltrate with parafocal emphysema; and early loculation of pleural exudate. These manifestations of staphylococcal pneumonia are becoming increasingly common in

Jonas A. Shulman, M.D.; Leon A. Phillips, M.D., and Robert G. Petersdorf, M.D., *Annals of Internal Medicine*, January, 1965.

infants and young children or patients with mucoviscidosis, postoperative states, and superinfections after broad-spectrum antibiotic therapy. Early diagnosis of staphylococcal pneumonia, followed by appropriate drug therapy, may avert mortality.

Gram-Negative Pneumonias

The incidence and severity of infections due to gram-negative pathogens other than the staphylococcus appear to be increasing, particularly in hospitalized patients whose normal bronchial flora is altered by antibiotics. Furthermore, the use of antibiotics *per se* may have increased the prevalence of these bacteria in the hospital. These pathogens are usually seen as superinfections but may produce primary pneumonia. The organisms include *Hemophilus influenza, Escherichia coli, Klebsiella-Aerobacter, Proteus,* and *Pseudomonas.*

H. influenza is frequently found in the sputum of patients with chronic lung disease and may be of etiologic significance in patients with chronic bronchitis. The relative rarity of acute *H. influenza* respiratory infections in adults does not warrant disregarding this organism as a pathogen, particularly in patients who develop acute infections against a background of chronic bronchitis, pulmonary emphysema, and bronchiectasis. Infections due to *H. influenza* call for treatment with tetracycline.

Friedlander's pneumonia occurs most commonly in alcoholics, diabetics, and patients with other debilitating disease. Early recognition is essential if therapy is to be effective.

In alcoholic patients, there are similarities between Friedlander's pneumonia and pneumococcal pneumonia. Cavitary disease has been probably more common in pneumococcal infection than has been supposed. Alcoholic patients with pneumococcal pneumonia and cavitary disease also often have bacteremia, shock, and leukopenia, and their prognosis is poor. Early recognition followed by prompt therapy is essential.

Sterile pleural effusions are a more frequent complication of pneumococcal pneumonia than true empyema. They may be associated with fever that is not affected by further antimicrobial therapy, suggesting that inflammation rather than the presence of bacteria is the most important determinant in the genesis of fever. Sterile effusions usually resolve without therapy. Drainage through a large lumen catheter may be indicated.

Some metastatic manifestations of pneumococcal pneumonia may be life-threatening despite very minimal pulmonary infection. There is the classical triad of pneumococcal meningitis, endocarditis, and pneumonia. Despite adequate antimicrobial therapy, the patient may be left a "cardiac cripple."

Complicating Conditions

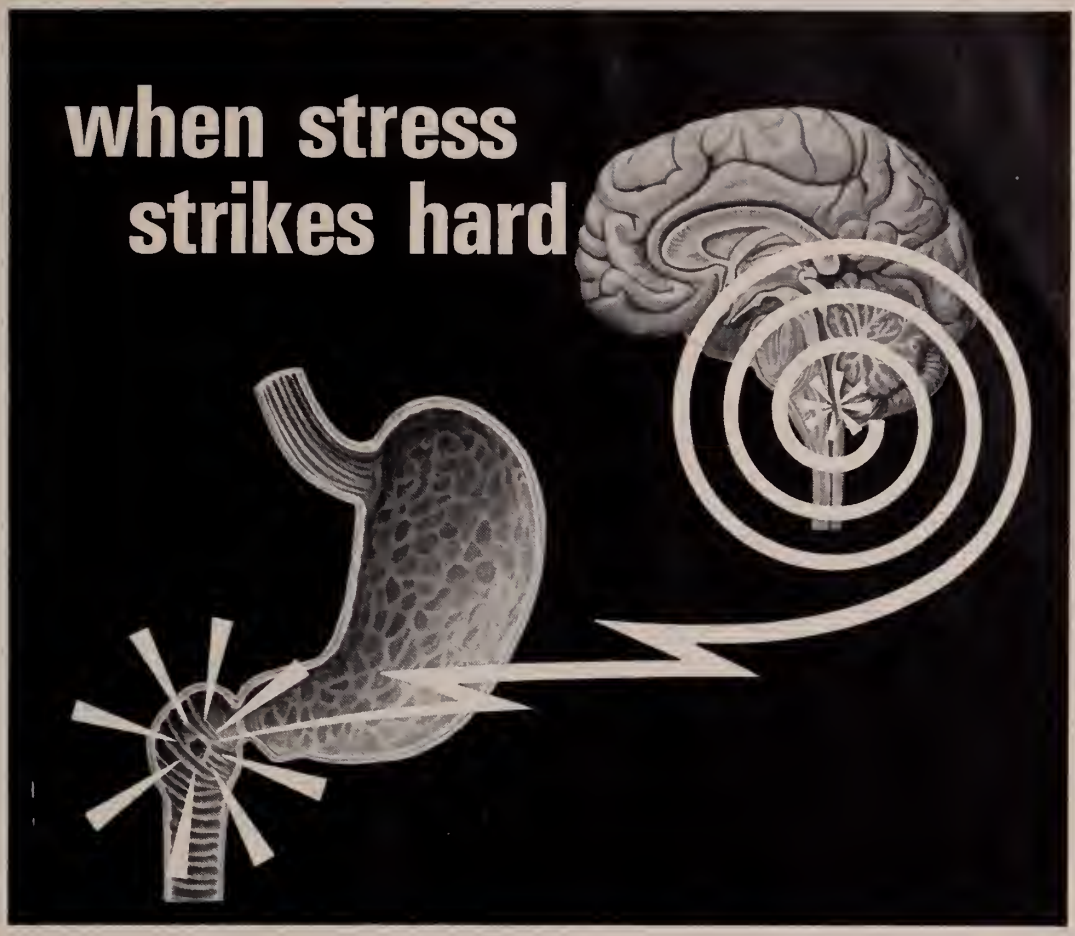
In some patients with slow resolution of bacterial pneumonia the infection fails to clear within four weeks. When patients over 40 have slowly resolving lobar consolidation and indolent rather than acute symptoms, surgical intervention should be considered.

Occasionally, but rarely, patients with acute respiratory disease have carcinoma and sometimes patients with low-grade pulmonary symptoms suspected of having tumors may have only pneumonia, which responds readily to antimicrobials.

A variety of other local and systemic conditions predispose to bacterial infection in the lung. Among the local factors are trauma, bronchostenosis, foreign body, aspiration, bronchiectasis, and cystic disease of the lung. Systemic diseases complicated by recurrent pulmonary infections include multiple myeloma, chronic lymphatic leukemia, agammaglobulinemia and hypogammaglobulinemia, the nephrotic syndrome, collagen vascular disease, splenectomy in children, and perhaps such a generalized disease as alcoholism.

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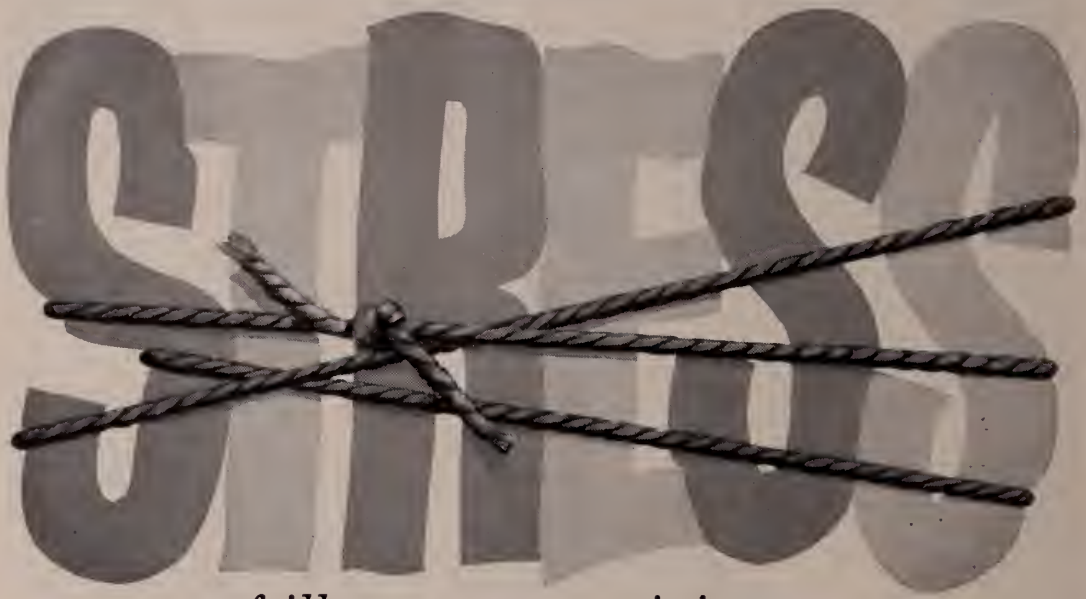
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*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

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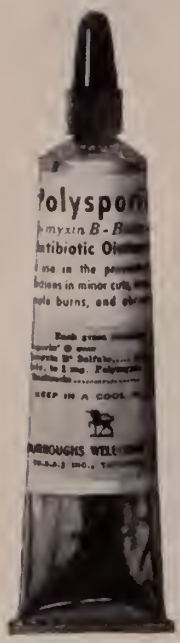
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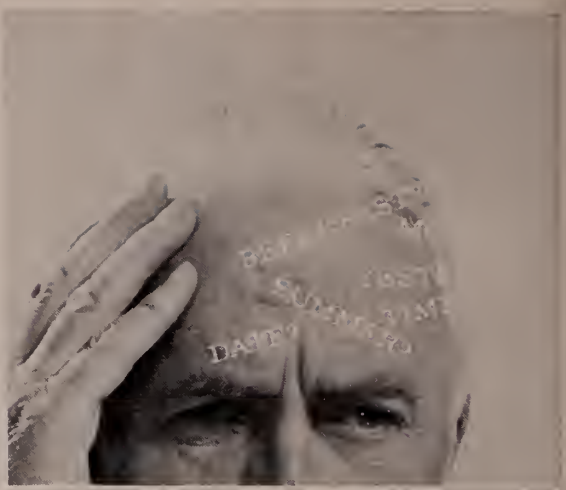
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For all alumni of the School of Medicine, Division of Graduate Medicine and ex-interns and ex-residents of University affiliated hospitals.

Seminars from 2:00 p.m. to 5:00 p.m. in

Otolaryngology	Medicine
Psychiatry	Ophthalmology
Pediatrics	Surgery

Neurology - Neurosurgery - Neuroradiology

Registration in the lobby of the Maloney Building, 36th & Spruce Streets, Philadelphia, beginning at noon. No registration fee.

Conference Dinner in the University Museum beginning with cocktails at 5:30 p.m. Dinner reservations are $5.00 per person

For additional information write to the Medical Development Office, 320 South 34th Street, Philadelphia, Pennsylvania 19104

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

SURGERY AND GENERAL PRACTICE—

Ralph N. Lee, M.D., Veterans Administration Hospital, Fort Howard, Maryland. Howard University Medical School 1960. General surgical residency. Available July 1965.

NEUROSURGERY (partnership or solo)—

Mario Ludmer, M.D., 256 Highland Avenue, Pittsburgh, Pa. 15229. University of Buenos Aires School of Medicine 1956. Board eligible. Available immediately.

GENERAL PRACTICE—

Edward G. Krug, M.D., 142 Merson Drive, Buchanan, Michigan 49107. Wayne State University 1958. Available immediately.

PATHOLOGIST—

James Ernest Haines, M.D., Worcester Foundation for Experimental Biology, 222 Maple Avenue, Shrewsbury, Massachusetts. Stanford University Medical School 1955. Board certified in Anatomical Pathology. Board eligible in Clinical Pathology. Available October 1966.

Chairmen of Councils and Committees 1965-1966

Air Pollution	Roslyn Barbash, M.D.
Annual Meeting	Jerome G. Kaufman, M.D.
Cancer Control	John L. Olpp, M.D.
Child Health	Robert E. Jennings, M.D.
Chronically Ill and the Aging	Matthew E. Boylan, M.D.
Conservation of Hearing & Speech	
Conservation of Vision	Ralph E. Siegel, M.D.
Credentials	Marcus H. Greifinger, M.D.
Disaster Medical Care	Jack R. Karel, M.D.
Finance and Budget	Thomas C. DeCecio, M.D.
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Occupational Health, Rehabilitation, Workmen's Compensation	Joseph A. Lepree, M.D.
Publication	George B. Sharbaugh, M.D.
Public Health	John B. Fuhrmann, M.D.
Public Relations	Harry F. Suter, M.D.
Retirement Plan for Physicians	Nicholas E. Marchione, M.D.
Revision of Constitution and Bylaws	Louis F. Albright, M.D.
Traffic Safety	
Woman's Auxiliary Advisory	George O. Rowohlt, M.D.



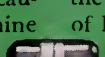
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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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THE JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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JULY, 1965 Vol. 62, No. 7

199th ANNUAL MEETING
TRANSACTIONS ISSUE

0th ANNIVERSARY MEETING
May 14-18, 1966

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to assure pain relief in relaxant therapy

In painful skeletal muscle spasm, relief of pain does not always follow relaxant therapy, as in the presence of—

Provocative pain, when muscle spasm is triggered by some underlying musculoskeletal defect.

Residual pain, when relaxation of severe spasticity leaves a degree of myalgia that continues to cause discomfort.

Severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

Emotionally aggravated pain, when anxiety or agitation creates tensions that undermine the efficacy of relaxant medication.

For decisive relief—lest persistent pain overshadow the benefits of relaxant therapy—many physicians prescribe ROBAXISAL or ROBAXISAL-PH.

Synergistic double action

In ROBAXISAL the potent action of the well-recognized skeletal muscle relaxant Robaxin (methocarbamol)[1,2,3,4,5,6,8] is accompanied by the time-tested analgesia of aspirin. This "rational therapeutic combination"[7] proves especially effective, since clinical studies have attested that the concurrent ingestion of methocarbamol and aspirin produces higher salicylate levels than equivalent doses of aspirin alone[7]...with "gratifying relief" of pain as well as spasm.[7]

INDICATIONS: Strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

CONTRAINDICATIONS: Hypersensitivity to any one of the components.

SIDE EFFECTS: Lightheadedness, slight drowsiness, dizziness and nausea may occur rarely in patients with unusual sensitivity to drugs, but usually disappear on reduction of dosage.

Supplementary sedation

In ROBAXISAL-PH, the relaxant Robaxin is combined with the analgesic-sedative ingredients of the popular Phenaphen formula, for use when emotional tensions aggravate the spasm-pain syndrome. Anxiety is eased by the phenobarbital component, which also enhances analgesic effects; and any tendency to gastric upset is minimized by hyoscyamine in the formulation.

References: 1. Carpenter, E. B., South. M.J. 51:627, 1958. 2. Crookshank, J. W.: J. Louisiana State Med. Soc. 114:272, 1962. 3. Feinberg, I., et al.: Am. J. Orthoped. 4:280, 1962. 4. Fitzgerald, W. J.: Miss. Valley M.J. 82:146, 1960. 5. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 6. Meyers, G. B., and Urbach, J. R.: Penna. M.J. 64:876, 1961. 7. Truitt, E. B., Jr., Morgan, A. M., and Nachman, H. M.: South. M.J. 54:318, 1961. 8. Weiss, M., and Weiss, S.: J. Am. Osteopath. Assn. 62:142, 1962.

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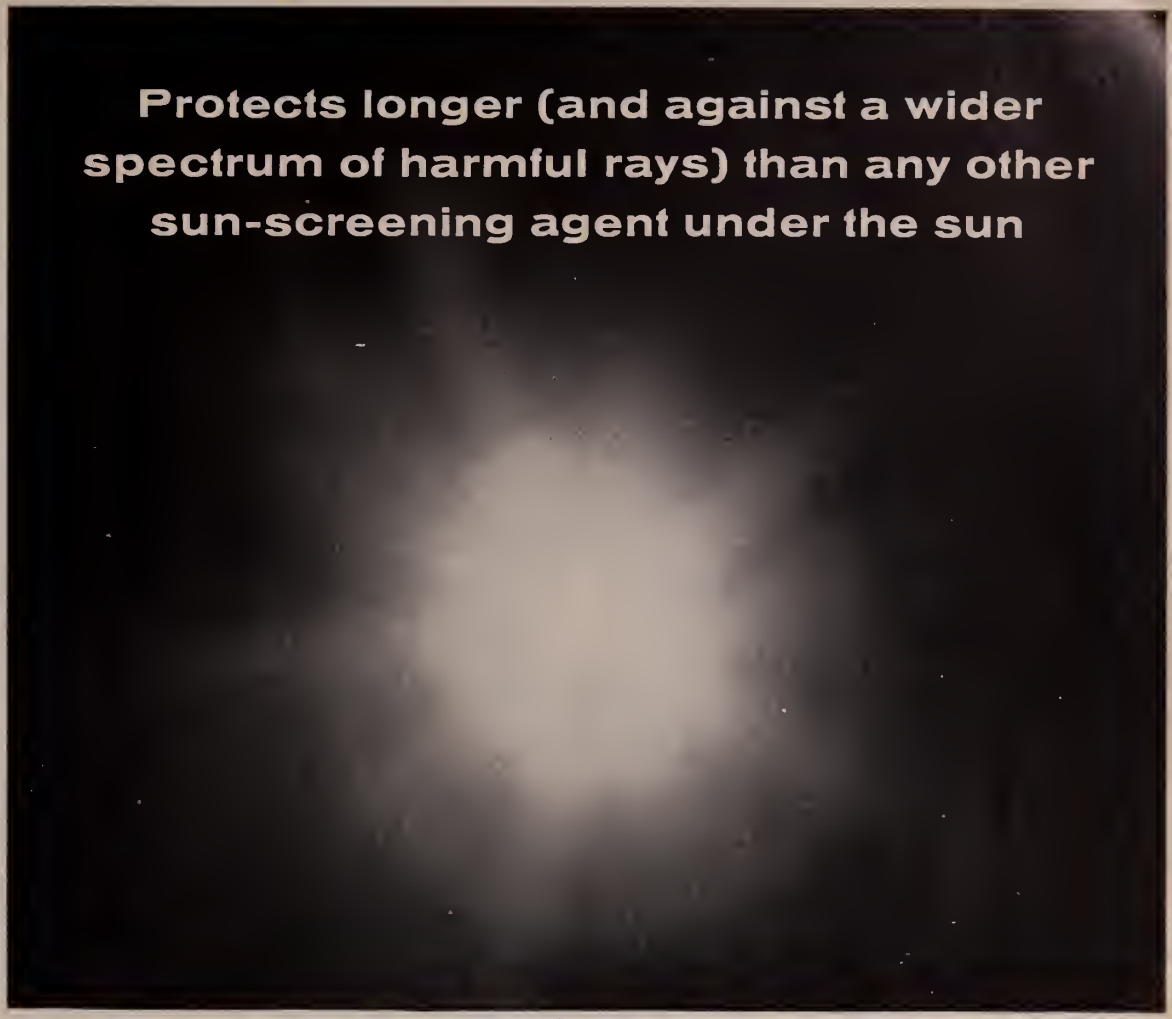
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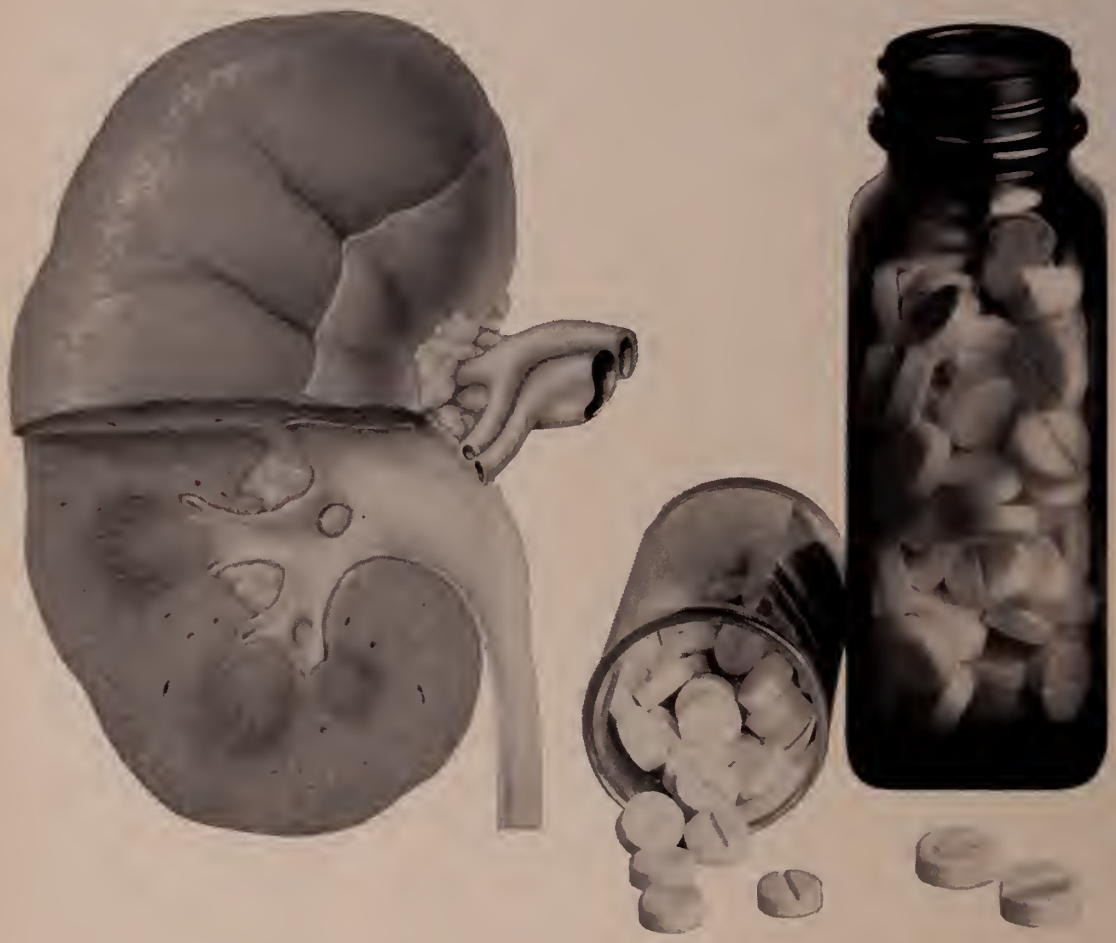
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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Provocative pain, when muscle spasm is triggered by some underlying musculoskeletal defect.

Residual pain, when relaxation of severe spasticity leaves a degree of myalgia that continues to cause discomfort.

Severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

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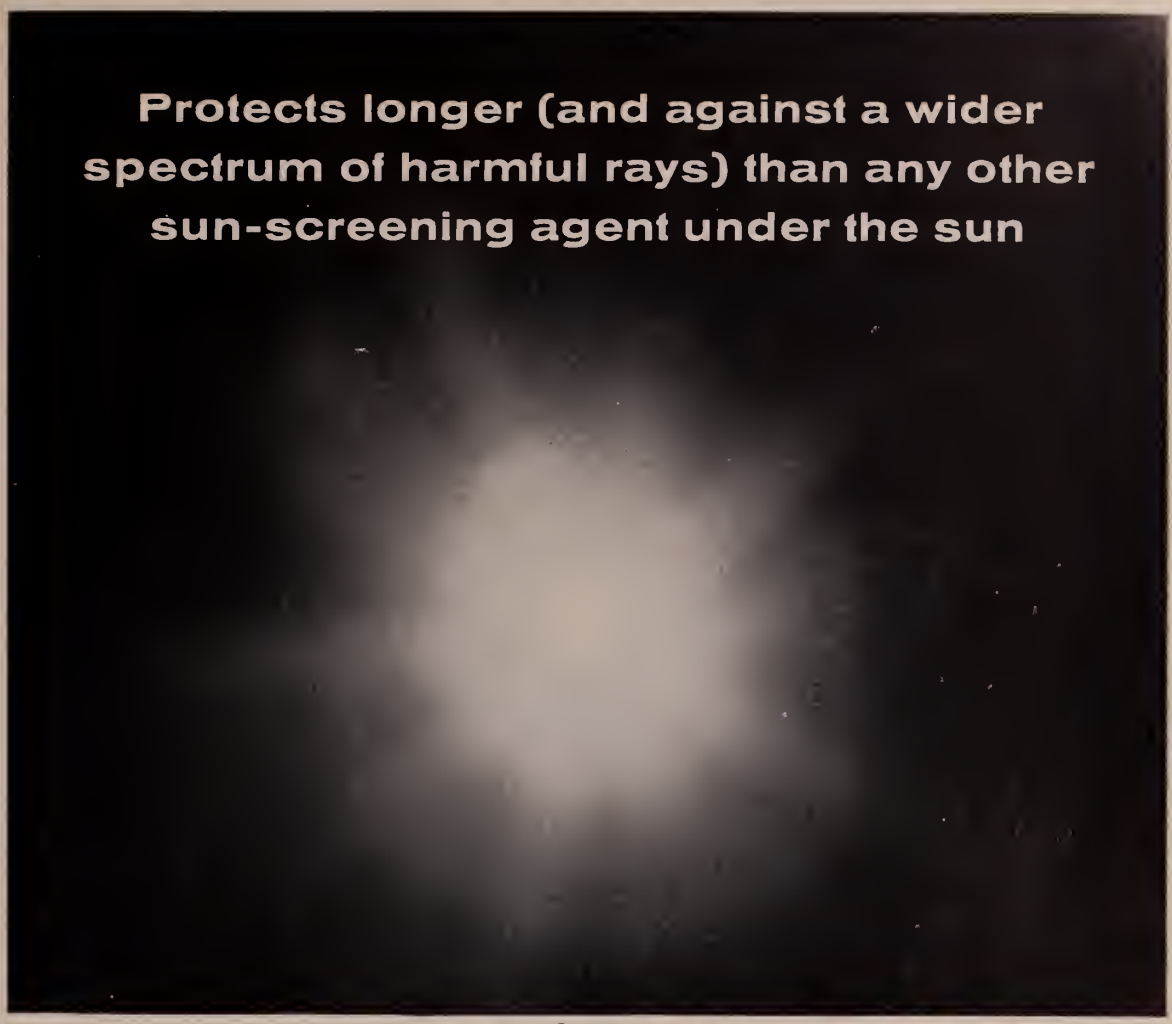
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She's tense, high-strung, a compulsive eater —the type of patient who may overreact to plain amphetamine—yet fails to respond at all to less potent drugs.

What's the answer? Desbutal Gradumet.

Why? Because the product calms her anxieties even as it controls her compulsive urge to eat. This dual therapy is a result of two tablet sections, combined back to back, each with its own release rate. One section contains Desoxyn® (methamphetamine) to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Thanks to the unique Gradumet, both drugs are released in an effective dosage ratio, **minute by minute throughout the day.** The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract. **The release is continuous and controlled.**

It's this predictable release that makes the difference for your patients. Dosage is just once a day.

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Desbutal 10—10 mg. Methamphetamine, 60 mg. Pentobarbital.
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Gradumet—Long-release dose form, Abbott. 507225

ABBOTT

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NTZ Nasal Spray relieves hay fever symptoms on contact

Fast symptomatic relief from seasonal hay fever comes in the convenient NTZ Nasal Spray bottle. Two sprays quickly relieve itching and decongest the nasal membranes on contact. The first spray of NTZ shrinks the turbinates, helps restore normal nasal ventilation and breathing. After a few minutes a second spray enhances sinus ventilation and drainage.

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NTZ is supplied in leakproof, pocket-size, spray bottles of 20 ml. and in bottles of 30 ml. with dropper

Winthrop Laboratories, New York, N. Y. 10016

NTZ, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine), and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U.S. Pat. Off.

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prescribe NTZ® Nasal Spray



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When you put patients on "special" fat diets..

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And once they've tried it, they can tell you that no margarine can match Mrs. Filbert's flavor.

Mrs. Filbert's Corn Oil Margarine is a special margarine* made from 100% corn oil, over 50% of which retains its liquid characteristics.

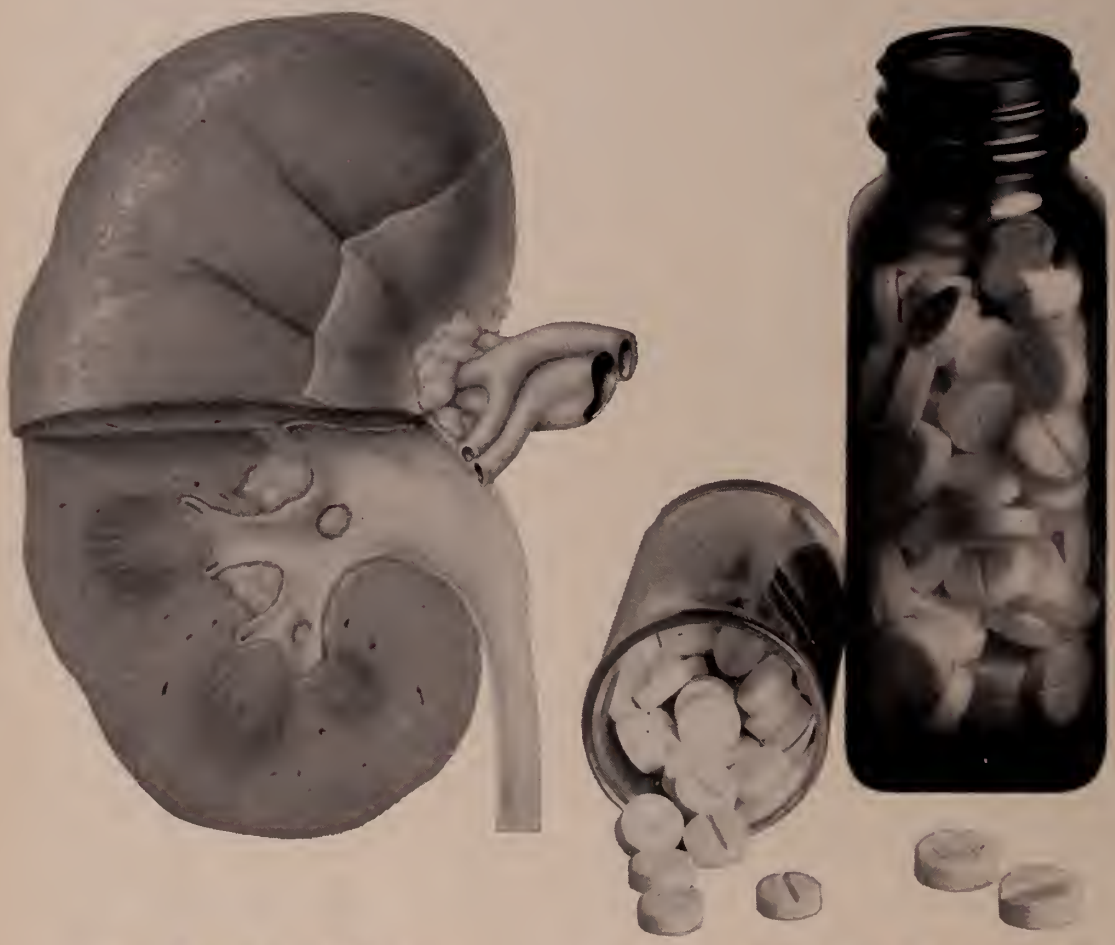
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For additional information, including detailed listings of component characteristics, please write to us: J.H. Filbert, Inc., Baltimore 29, Maryland.



* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa

where today's theory is tomorrow's therapy



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.





Keeping an eye on the scales may be an avocation with some people, but it is a full-time occupation for Lilly employees who determine the weight of filled tubes of medication. First, a random sampling of empty tubes is taken, and the average weight is calculated. Then, the amount of ingredient is added to this figure to determine the standard fill. As the machine fills the tubes, a sample—about one out of every four hundred—is weighed and checked against the standard. The weights are plotted on a graph. A variation of three consecutive points in either direction indicates a trend away from the standard, and the machine is adjusted. Tolerances are kept to less than 5 percent. An extra step . . . but consistent with the meticulous program at Eli Lilly and Company to assure the highest quality in our finished products.

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EDITORIALS

The Three Layered Cake

The word "cake" has long had a symbolic meaning. Thus, there is the well known, if imperfectly understood, phrase "You can't eat your cake and have it, too." There is the analogous phrase "pie in the sky."

In his interesting address to our Annual Meeting on May 16, Dr. James Z. Appel (AMA President-elect) drew an ingenious metaphor comparing some current efforts to provide hospital care for the aged with the provisions of a cake—"Medicake," of course. He even looked up the word "cake" in standard dictionaries and found that one of them defined cake as a "a sweetened composition . . . baked in a loaf or mass of any size or shape"; and the other offered, as a definition: "a mass of dough baked on both sides." The application of either — (especially the latter) — is obvious. And then there are those to whom it is either devil food cake or angel cake (not to mention selling it like hot cakes).

Frosting on a cake sometimes sweetly conceals certain ingredients. In this case, the complexity and layering of the cake would have made it desirable to submit it to thorough and deliberate inspection. The House, regretably, did not hold hearings on this bill. Popular interest was obvious — indeed, the AMA reports that it received more than 22 million requests for pamphlets and brochures on the subject, making this, by any measure, the hottest issue in AMA history. (Hot cakes again.)

It may not be just what the doctor ordered; but in some respects it takes the cake. And no matter how you slice it, it is still a cake: a mass of dough, covered by frosting and nicely sweetened. And to those who cry for the bread, it offers the traditional answer: "Let them eat cake!"

The First Two Hundred Years Are The Hardest

We couldn't let July 1965 slip by without telling all our readers that The Medical Society of New Jersey was founded July 23, 1766. On this July 23, we enter our 200th year. We are, of course, older than the United States of America, older than the AMA, older than any medical society in this hemisphere. But age isn't everything. Let us hope that we will merit our standing in New Jersey civic life not by reason of our age, but by reason of our services to the public. But having reached the end of our second century, we conclude that we must have been doing something right. Wait till next year, when we put the 200th candle on our birthday cake!

Anxiety About Illegal Commitment

Citizens whose reading is largely confined to the comics have a new big bad wolf to worry about. It seems that Little Orphan Annie and Daddy Warbucks are being confined to a mental hospital without due process. If any of your patients are losing sleep about this, the simple truth may be more solacing than a fistful of tranquilizers. In the first place, most mental hospitals are so crowded now that they have wall-to-wall beds, and the last thing the hospital administrators need or want is more business. In the second place, to be committed to a mental hospital in New Jersey, the papers must be signed by an applicant, two physicians, and a judge. If your patient fears that these four good people will gang up on him in an evil conspiracy, perhaps he will be reassured when the unlikelihood of enlisting so distinguished a corps of conspirators is pointed out to him. In the third place, the *habeas corpus* exit door remains wide open, and if a committed patient still feels victimized, no hospital administrator can stop him from applying for this writ; and then the doctors will have to satisfy another judge that hospital confinement is necessary; and must

submit themselves to cross examination by the patient or his attorney during this hearing.

Why the cartoonist is using Little Orphan Annie to scare the daylights out of the more gullible (comic-reading) segments of the public is any one's guess. What's yours?

The Doctor As A Patient

We aren't very good patients, really. The therapist is flattered at being asked to take care of one of his professional brethren. But he has anxiety, too. There is that extra ounce of responsibility, of course. Sensitivity to the fact that this patient is a severe and knowledgeable critic; and above all, a destruction of the mystique of "doctor knows best"—a charisma which, in spite of all our clay feet and in spite of a spate of image-breaking, is still a prime ingredient in good medical care.

A physician is likely to be dilatory in seeking professional help. To some extent this may be due to reluctance to impose upon a colleague. To tie up your gastro-enterologist colleague all morning with a gastro-intestinal x-ray series does seem a bit unfair when your disability could be handled by a little aluminum hydroxide gel. Again, the doctor-patient may prefer the more benign explanation for a symptom: may assume that rectal bleeding means hemorrhoids, not a carcinoma; or that a swollen lymph node is surely the result of a trivial distant infection and not a Hodgkins Disease. Thus believing what he wants to believe, he delays in seeking diagnostic studies—a casualness he would condemn in any other intelligent patient. Or the reverse can be true. Familiar with the serious possibilities, he sees multiple sclerosis in every transient diplopia; congestive heart failure with any briefly labored breathing; and creeping parkinsonism with the slightest hard tremor. Neither his exasperating casualness nor his terror-stricken hypochondriasis makes him a good patient.

And how can one doctor give orders to another? The lay patient, we hope, will take it on faith. The M.D. patient wants to know why. And no matter how effective a placebo has been with your unsophisticated patient, would you prescribe it for a physician?

Then, too, there is the tradition (not, alas a myth) that with doctors and their families anything that *can* go wrong will go wrong. It is the physician's child who seems to develop the most profuse post-tonsillectomy bleeding. Doctors' wives, for some reason still undiscovered by medical science, seem more allergic to the common potent drugs than the wives of barristers, butchers, and bartenders.

So, as Gilbert put it (in a far different context), the practitioner asked to treat a colleague must feel like singing: "Although the compliment implied inflates me with legitimate pride, still it cannot be denied, it has its inconvenient side."

Looking for a subject for a Ph.D. thesis? Here's an idea free. Make a study of the relative effectiveness of the medical practitioner in handling the same illness in an M.D. patient and in a non-medical patient.

Down The Drain With Your Old Drugs

When you toss old or unwanted drugs into the trash can, you are setting up an attractive nuisance for children and scavengers. When you throw away syringes and needles, you are holding open house for narcotic addicts who would rather use your second hand equipment than the crude ones they can make. So with old and unwanted drugs and supplies, the rule is simple: incinerate, strip off labels, package discarded supplies in concealing container, or wash old medications down the drain. Commissioner Kandle says that the State Health Department actually gets letters from citizens who have watched scavengers, children, and presumptive addicts rummaging through the trash cans of New Jersey doctors. You may be putting out a better grade of garbage than your neighbor—but this is one status symbol you can do without.

199th ANNUAL MEETING
Haddon Hall, Atlantic City
MAY 15-19, 1965

Official Transactions Of the House of Delegates

THE MEDICAL SOCIETY OF NEW JERSEY

NOTE TO READERS

The annual reports and transactions of the House of Delegates of the 199th Annual Meeting of The Medical Society of New Jersey are bound together in this issue of THE JOURNAL.

Actions taken by the House of Delegates are indicated in bold-face small type in the reports.

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ANNUAL REPORTS

President

Charles H. Calvin, M.D., Perth Amboy

(Reference Committee "A")

Time seems to have assumed a strongly accelerated pace since I entered upon the presidency of The Medical Society of New Jersey. In retrospect it seems to me that the impression of its swift passage has been heightened by the multiplicity of matters to be dealt with and the crowding pressures of engagements to be kept, obligations to be met, and tasks to be accomplished. This has been for me a truly active, interesting, and enriching year. My one hope is that in the perspective of time to come it will prove to have been a year of advantage and of advancement to the fundamental good of our Society.

The activity of the president's year derives from his involvement in the deliberations and undertakings of all of the operational units of the Society, such as the Board of Trustees, the four administrative councils—with their numerous satellite committees—the standing committees, the special committees of the Society and of the Board, the liaison committees with other professional groups, and the conference committees. It is added to by his involvement in contact and consultative operations, with the American Medical Association, for example, and all its divisions, departments, councils, and committees; with the agencies of state government, likewise; with component and neighboring medical societies, and with lay organizations whose purpose is related in some way to areas of concern proper to Medicine.

The president's year is inevitably interesting, because it leads him into so many and diversified fields. I have found that the province of presidential participation ranges widely from matters of federal legislation and supreme court regulatory provisions, through the complex business of health insurance and the survival of free enterprise, and all the way down the scale of demanding concerns to the level of decision as how to get rid of the hordes of pigeons that paid overzealous tribute to our headquarters building.

The year of the presidency is enriching because it is so informative and enlightening concerning so many subjects and processes, and because it affords one the benefit of association with so many able, earnest, and generous individuals who give of their time and judgment in order to advance the causes that they have espoused and the programs with which they have identified themselves.

I approach the end of my term of office with a sense of profound indebtedness to, and admiration for, all with whom I have been privileged to work. I have been strongly impressed with the devotion of the Board of Trustees to the true good of our Society, as I have been impressed also by the constancy and wholehearted dedication of the members of our councils and committees and of the members of our staff.

This year we have had closer rapport with component societies through joint meetings of presidents of component societies with our Board of Trustees. I hope that those meetings will continue and that, in a changing world, we will in The Medical Society of New Jersey retain an unchanging unity of lofty purpose and action that will effectively preserve in the profession of Medicine in New Jersey the character and distinctions that for two hundred years have given it honor and worth.

Approved (page 343)

Board of Trustees

Nicholas A. Bertha, M.D., Chairman, Wharton

(Reference Committee "A")

Full minutes of the meetings of the Board of Trustees have been distributed regularly to component societies, and summaries of its significant actions have been highlighted in *The Journal*. Therefore, as has been the custom, this report of the Board of Trustees will cover only such items as are not reflected elsewhere in the individual reports of committees and/or councils.

The Society's business continues to make heavy demands upon the time of the Trustees. Twelve meetings will have been held prior to this annual meeting, each one lasting a full day or afternoon and evening. The Board members have served loyally and diligently. Average attendance at meetings has been 90%-100%. The councils and numerous committees have, by their work and comprehensive reports, greatly facilitated the orderly conduct of the Society's business.

Routinely, the Board has dealt with general matters brought to its attention: correspondence and resolutions from members, component societies, the American Medical Association, and outside organizations; appointment of representatives to local, state, and national meetings of concern to this Society; nomination of candidates for the State Board of Medical Examiners; consideration of, and action on, the reports and recommendations of the councils, standing, and special committees; cooperation with the department of state government and with the allied professions.

Approved (page 343)

CONFERENCE OF PRESIDENTS

(Reference Committee "A")

As a result of a request from the Monmouth County Medical Society (that arrangements be made for meetings of component society presidents at the executive offices at which free and open discussions would be encouraged for improved mutual understanding of problems of the State Society as well as of the component societies) and as the result of inquiry made to the presidents to ascertain their wishes in the matter, the presidents of the component societies were invited to meet in the executive offices in the morning of a regular Board meeting day, to lunch with the Board, and to meet jointly with the Board in the afternoon.

The first conference and joint meeting were held on October 18, 1964. Fifteen component societies were represented. The second was held on March 21, 1965, with 12 societies represented.

The presidents reported that their conferences were most enjoyable and very profitable. They made the following suggestions for future meetings: (1) that the president and the president-elect of each component society be invited to future conferences, and that it be urged that at least one of them attend; and (2) that two meetings a year be continued—one in the fall and one in the spring.

Among the items discussed by the presidents were several referrals from the Board of Trustees, among them:

1. *Sponsors of Resolutions* . . . Any county or delegate that sponsors a resolution should be represented before the reference committee to which the resolution is referred by some one well-informed concerning the resolution and able to speak in its behalf.

The presidents were in agreement with this suggestion.

2. *Proper Wording of Resolutions for MSNJ Action* . . . Experience has demonstrated that some resolutions submitted for consideration by the House of our Society contain defects in content and form which impair their effectiveness. Suggestion is made that county societies authorize the Executive Director to review resolutions which they or their delegates or members submit, for the purpose of making editorial changes agreeable to the sponsor.

The presidents were in agreement with this suggestion.

3. *Amendment of Reference Committee Reports . . .* Extensive oral amendment of reference committee reports, made from the floor of the House, is confusing to the members of the House. It would be much more satisfactory if such amendments were submitted to the office for mimeographing and distribution to the House at the time at which reference committee reports are being considered. Since reference committee reports are usually available through the office the afternoon before their consideration in the House, members interested in a particular report can obtain copies in advance. If a member then desires to make an amendment, he could proceed as indicated.

Provided the suggestions will not put an end to oral discussion from the floor of the House, the presidents were in agreement with the idea.

Among other items discussed by the presidents at their conferences and at the joint meetings with the Board were: attendance of county delegates at annual meetings, statewide emergency medical coverage, drug prescriptions for welfare patients, insurance programs, associate membership, physician-hospital relationships, medical services under Blue Cross, ambulatory patients, AMA-ERF contributions, narcotic addiction, press releases, and out-of-state bio-analytical laboratories as they have been affected by recently enacted state legislation.

Approved (page 343)

INTER-RELATIONS WITH THE JUDICIARY AND BAR

(Reference Committee "A")

At the call of the chairman of the Supreme Court of New Jersey's Committee on Relations with the Medical Profession, the Society's Conference Committee with the Judiciary and the Bar met to discuss the outline of the proposed panel for the screening of malpractice cases. This proposal has been under consideration by the Supreme Court, but because of certain objections coming from members of the legal profession adoption has been delayed. From the remarks of those present from the bench and bar at this year's meeting, it was evident that the lawyers objected chiefly to three sections of the proposal. There was extended discussion concerning the matters under consideration, and although numerous ideas for constructive amendment were offered nothing specific was agreed upon in final form. It was agreed that selected representatives of both committees would meet for the purpose of drawing up a suggested revision of the contested sections. The revision will be submitted to MSNJ for study and action subsequently.

Supplement Report

Proposed Professional Liability Panel

This version represents the present status of these proposals. It is not to be regarded as the final form because conferences are still being held and considerations indulged that may involve further change originating either with The Medical Society of New Jersey or the representatives of the bench and the bar.

This copy is presented at this time for the information of the House to the end that it may study the proposals in their present form and afford to the Board of Trustees such advice and suggestion as the House may feel necessary or desirable.

DRAFT

STATEMENT OF PURPOSE AND INTENT

1. A professional liability panel to evaluate medical negligence claims shall be established by rule of the Supreme Court with the the cooperation of The Medical Society of New Jersey to function on an experimental basis for an indefinite period in all counties.

2. It is understood by the members of both professions that there can be no legal sanction against a claimant who breaches an agreement not to institute legal proceedings, or to drop pending litigation.

3. The Medical Society of New Jersey cannot assure what opinion will be given to a claimant by any physician made available under Section 14. It will invite the physician's participation as a qualified medical expert but without prejudice as to his report and testimony.

4. The members of The Medical Society of New Jersey reserve the right to submit these proposed rules to their respective insurance carriers for approval prior to adoption.

5. It is understood that these rules are subject to approval by the New Jersey Judicial Conference and will not become effective unless adopted by the New Jersey Supreme Court.

OUTLINE OF PROPOSED PROFESSIONAL LIABILITY PANEL

It would appear to be in the common interest of both the medical profession and the legal profession that some procedure he devised (A) to discourage baseless professional liability cases and (B) to make expert medical testimony available in those professional liability cases where there is a reasonable basis for the claim. To accomplish these objectives, the following program is suggested:

1. A professional liability panel to evaluate alleged medical negligence claims shall be established by rule of the Supreme Court with the cooperation of The Medical Society of New Jersey to function on an experimental basis for an indefinite period in all counties.

2. The panel shall be composed of a number of doctors designated by The Medical Society of New Jersey and a number of attorneys designated by the Supreme Court. Men appointed to the panel should be of high standing with hroad professional hackgrounds rather than men highly specialized in particular fields.

3. Where a claim is submitted to the panel for evaluation it shall be referred to a sub-panel composed of two doctors, two attorneys, and a retired Justice of the Supreme Court, or a retired Judge of the Superior Court, or County Court who shall be designated as Chairman.

4. The identity of the sub-panel shall not he made known to either the person submitting the claim or to the doctor against whom the claim is made prior to the actual hearing.

5. The subpanel shall be named by the Administrative Director of the Courts, from lists of doctors furnished by The Medical Society of New Jersey and attorneys designated by the Supreme Court. The place and time of hearing shall be fixed by the Administrative Director of the Courts.

6. All persons claiming damages by reason of injury or death resulting from alleged medical negligence shall be encouraged by every available means to make an informal and voluntary suhmission of their claim to the panel for evaluation either prior to or after the institution of legal action. It is preferahle that submission be prior to the commencement of action. The filing of a claim with the panel shall extend the time within which an action at law may be instituted for a period of 30 days after the panel advises the claimant of its determination.

7. When such a claim has been submitted, the doctor concerned shall be notified and both the claimant and the doctor shall be invited to submit to the panel any information relevant to the claim.

8. The sub-panel shall hold a hearing on the claim. The claimant and his attorney may attend. The doctor, his personal counsel and counsel for his insurance carrier may attend.

9. The claimant puts in his case, setting his facts before the sub-panel in whatever form he thinks appropriate. He can do it in the form of a narrative statement by his lawyer. He can do it in the usual courtroom form of question and answer. He can do it by written statement if he prefers. He may call witnesses if he prefers, or he may present sworn or unsworn statements of witnesses. The procedure shall be informal.

With the consent of claimant, the doctor or his attorney (personal or insurance) may question the claimant or a witness.

When the claimant has finished with his presentation, the doctor may in like manner put forth his version of the facts in any form he sees fit to use; and he may present witnesses or their sworn or unsworn statements.

With the consent of the doctor, claimant's attorney may question the doctor or his witness.

10. Both parties, through their respective attorneys, shall consent to the production of all necessary hospital and other records necessary to a full presentation of the facts.

11. Every oral or written statement by claimant, the doctor, by witnesses for either, or by their attorneys, shall be without prejudice.

12. After an evaluation of the information submitted, the subpanel shall advise the claimant and the doctor only as to whether, in its opinion, there is a reasonahle basis for the claim.

The report shall state either "We find there is a reasonable basis for the claim" or "We find that there is not a reasonable basis for the claim." No opinion shall be given with respect to the extent of damages.

13. When the sub-panel advises that there is no reasonable basis for the claim, it shall recommend to the parties either that no legal action be instituted, or, if legal proceedings are pending, that they be discontinued. When the sub-panel advises that there is a reasonable basis for the claim it shall recommend that an amicable settlement of the claim be considered.

14 (a). The person submitting a claim *may* (but need not) agree in advance not to institute legal proceedings or to dismiss any proceedings that may he pending in the event the sub-panel is of the opinion that there is no reasonable basis for the claim.

14 (b). If the person submitting a claim does agree in writing, as provided in Section 14 (a), and if the subpanel is of the opinion that there is a reasonable hasis for the claim, it shall be agreed in advance that the Administrative Director of the Courts will supply three names of expert medical witnesses from a list compiled by The Medical Society of New Jersey, all or any to serve at a reasonable fee.

15. In the event the claimant does agree in writing as provided in Section 14 (a), the attorney submitting a case to a sub-panel shall have an agreement with the claimant and the sub-panel that should the sub-panel be of the opinion that there is no reasonahle hasis for the claim, the attorney will not institute legal action, or that he will withdraw as attorney in any proceeding that may be pending.

This shall not prevent the claimant from obtaining other counsel, if he so desires.

16. The testimony, statements, affidavits, findings, recommendations and records of the suh-panel with respect to any claim submitted to it shall not be evidential in any proceeding concerning such claim.

17. The circumstances under which an expert medical witness was made available, or the fact that he was made available under this plan shall not be made known to the trier of the facts.

18. If a sub-panel has determined that a claimant has

no reasonable basis for a claim, it may nevertheless re-hear the matter, upon the affirmative votes of three members of the sub-panel.

It shall not, however, grant any re-hearing in any matter in which the claimant or doctor has substituted counsel.

19. It is understood that the foregoing mechanism shall not be applicable in claims involving infants or other incompetents.

Referred back to the Board of Trustees and appropriate committees for further study and for the purpose of being put in a final completed form; then to be brought again before the House of Delegates for consideration. However, should it become necessary to act before the 1966 annual meeting, a special session of the House of Delegates is to be called to consider this.

Suggested that those delegates who feel that they have worthwhile suggestions make them known in writing to the Board of Trustees and/or the committees working on this matter. (page 343)

SPECIAL COMMITTEES

(Reference Committee "A")

In accordance with the action of the 1964 House of Delegates, the Board appointed a special committee "to study the special committee structure of the Society, with the throught in mind of streamlining the number of committees when their function seems to have lost substance."

The committee reviewed a resume of the activities of the special committees to the Councils on Public Health and Medical Services, together with their projected programs for 1964-65. The Special Committees on Occupational Health and on Workmen's Compensation (to the Council on Medical Services) were unanimous in their desire to merge. It was felt that the Special Committee on Rehabilitation to the Council on Public Health could also be included in the new joint group, in view of the mutual interest of rehabilitating workers for return to their jobs. The Board approved the study committee's recommendation that the merger of these three committees be effected, beginning with the new administrative year.

There was mixed feeling about the merger of the Special Committees on the Conservation of Hearing and Speech and the Conservation of Vision. Both were asked if they would agree to combine and to submit their reasons for or against merging. They replied and gave good and sufficient reasons why they should remain distinct. The Board agreed that they should so remain. It was also agreed that the following special committees to the Council on Public Health should continue as single committees: Cancer Control, Child Health, Chronically Ill and the Aging, Maternal and Infant Welfare, and Mental Health.

Study will continue on the general special committees—Disaster Medical Care, Medicine and Religion, Retirement Plan for Physicians, and Traffic Safety—and on the many special committees of the Board.

Approved (page 344)
Special committee to be continued.

FISCAL AND ADMINISTRATIVE YEARS

(Reference Committee "B")

On recommendation of the Audit Review Committee, the Board studied the possibility of changing the fiscal year to identify it with the calendar year, of changing the administrative year, and of changing the annual meeting month and days.

After review of available sites and dates, and after a thorough discussion of the question of changing the dates of the annual meeting, it was unanimously agreed that no change should be made from the present set up.

The dual questions of changing the fiscal and administrative years to coincide with the calendar year were discussed thoroughly and at length. It was concluded that the present system is superior to such changes, and that such changes would pose many problems in the transition. It was, therefore, unanimously agreed that no change should be made.

It was the further action of the Board that in future annual reports of the Committee on Finance and Budget there be included an ex-

planation of the division of dues income necessary for budgetary purposes.

The Board noted that the 1964 report of the Treasurer covered the 12-month period 5/1/63-4/30/64, and that the figures reported for activities in connection with *The Journal* and the Medical Student Loan Fund differed from the operational figures in the reports of the Committee on Publication and the Committee on Medical Student Loan Fund, both of which reported their financial activities for the 10-month period of 6/1/63-3/31/64. It was felt that presenting two sets of figures for two different periods was confusing. Therefore, the Board directed that the Committee on Publication and the Committee on Medical Student Loan Fund not include financial reports as part of their annual reports; that the financial reports of these two committees be included as part of the Treasurer's annual report; and that all reports cover the same period, with the same closing date.

Approved (page 347)

APPROVAL BY INDIVIDUAL DIAGNOSIS

(Reference Committee "C")

Last July the Commissioner of Banking and Insurance called a meeting to discuss ways of reducing overutilization of hospital services under the New Jersey Blue Cross Plan. He specifically requested MSNJ to attempt to find ways more effectively "to control admissions and unnecessary lengths of stay." He concluded: "If Blue Cross and the medical profession, hospitals, and Plan executives cannot find a way to continue operations under the new rates (granted in April 1964), I would be disposed to deny any further increases and to question whether the Plan might have outlived its usefulness to the public." Following that meeting, he expressed his concern to the public through a newspaper release. He made it clear that the "status quo" as regards the control of Plan utilization could not continue without jeopardy to the very life of the New Jersey Blue Cross Plan.

As an approach to the problem of containing utilization, the Permanent Committee on Blue Cross and Blue Shield (made up of representatives of MSNJ, the New Jersey Hospital Association, and the New Jersey Blue Cross and Blue Shield Plans) renewed recommendations for the establishment and efficient operation of utilization committees in New Jersey hospitals, and undertook development of data aimed at determining the maximum average inpatient stay for some 300 diagnoses without complication. The presidents of medical staffs of voluntary general hospitals and committee members of MSNJ were requested to cooperate in this program. It was made unmistakably clear by the President of Hospital Service Plan of New Jersey (New Jersey Blue Cross) that the requested maximum durational limits for specific diagnoses when compiled would not be used for the purpose of cutting off Blue Cross subscribers from further necessary hospitalization coverage, but would serve as the basis for initial approval and subsequent recertification, instead of using an arbitrary basis of 14 to 21 days as heretofore. It was the opinion of the Board of Trustees of MSNJ that it would be much more practical and accurate to deal with duration of stay on this new basis.

The schedule of diagnosis-based recertification intervals, developed from the survey returns and from Blue Cross statistics, was approved by the Board of Trustees for adoption by New Jersey Blue Cross as an experimental study for one year. It was approved on those same terms by the New Jersey Hospital Association.

The Board recommended to HSP that instead of the International Nomenclature used in the draft of the schedule it use the Standard Nomenclature, so that physicians will recognize the procedures referred to.

Under date of March 29, 1965, HSP distributed to all New Jersey physicians and hospital administrators the "Manual of Approval by Individual Diagnosis (AID)," with the announcement that the AID program will apply to all hospital admissions of New Jersey Blue Cross members on and after May 1, 1965.

Approved (page 348)

MSP BOARD OF TRUSTEES NOMINATIONS

(Reference Committee "C")

The following nominations were approved by the Board of Trustees and referred to the House of Delegates for action:

Also nominated for membership, to serve during their respective terms of office, are the Chairman of the Board of Trustees of the Hospital Service Plan of New Jersey, the President of the New Jersey Hospital Association, and the President of The Medical Society of New Jersey.

Approved (page 348)

Three year term (1965-68):

Name	*Type of Practice*	*Member of Component Society*
Rudolph C. Schretzmann, M.D.	Obstetrics	Bergen County
Edward W. Sprague, M.D.	Surgery	Essex County
Charles O. Tyler, M.D.	Pediatrics	Camden County
Thomas J. White, M.D.	Internal Medicine	Hudson County
Lloyd Felmly	Retired Newspaper Editor	

For the record, the following are the remaining members of the MSP Board of Trustees:

Terms expiring 1966:	*Type of Practice*	*Member of Component Society*
Charles W. Barkhorn, M.D.	Otolaryngology	Essex County
Irving P. Borsher, M.D.	Internal Medicine	Essex County
Robert G. Boyd	Hospital Administrator	
Charles L. Cunniff, M.D.	Internal Medicine	Hudson County
Andrew P. Dedick, Jr., M.D.	Radiology	Monmouth County
Sidney I. Simon, Ph.D.	College Professor	
Robert E. Verdon, M.D.	General Practice	Bergen County
Gustave Wiedenmayer	Banker	
Terms expiring 1967:		
Joseph P. Donnelly, M.D.	Obstetrics	Hudson County
*Edgar P. Eaton, Jr.	Businessman	
Joseph I. Echikson, M.D.	Internal Medicine	Essex County
Edwin T. Ferren, D.O.	General Practice	
*Mortimer J. Fox, Jr.	Businessman	
Jerome G. Kaufman, M.D.	Internal Medicine	Essex County
Joseph M. Keating, M.D.	Obstetrics	Passaic County
Elton W. Lance, M.D.	Surgery	Union County
Samuel J. Lloyd, M.D.	Surgery	Mercer County
Jesse McCall, M.D.	Internal Medicine	Sussex County

GROUP HEALTH INSURANCE

(Reference Committee "C")

As reported last year, on July 1, 1963 the Supreme Court declared unconstitutional N.J.S.A. 17:48 A-2—requiring approval of medical service corporation board members by an association of not less than 2,000 licensed physicians—which has been in existence for at least ten years.

On July 15, 1964, the New Jersey Supreme Court, by a vote of 5-2, declared unconstitutional N.J.S.A. 17:48 A-3—requiring that 51% of all the physicians in any county must be enrolled as participating physicians before a medical service corporation can transact business in that county.

GHI of New Jersey communicated with the Board, announcing that it was in the process of formulating a program for health insurance in the State of New Jersey and suggesting that it would be most helpful if the views of organized medicine could be considered during this stage of GHI's formation. Request was

* Original nominations approved by Board of Trustees of MSNJ, through mail poll, on January 10, 1964; confirmed by Board at meeting on July 19, 1964.

made for an opportunity to explore the matter with the Board. By invitation, two GHI representatives met with the Board and explained the operation of GHI of New York and its relationship with organized medicine there and expressed the hope that MSNJ would extend like cooperation. The Board took no action on the matter.

Approved (page 348)

MSA BOARD OF GOVERNORS NOMINATIONS

(Reference Committee "C")

The following nominations for membership on the Board of Governors of Medical Service Administration for 1965-66 were approved by the Board of Trustees and are referred to the House:

Charles W. Barkhorn, M.D.
Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Joseph I. Echikson, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

Approved (page 348)

GENERAL PRACTICE

(Reference Committee "D")

Implementing resolution #68, adopted by the AMA House of Delegates at its 1963 annual meeting, the AMA Board of Trustees informed medical schools of the shortage of general practitioners and requested their cooperation in exposing medical students to general practice by lectures, preceptor programs, and clinical instructors who are active general practitioners; the AMA Board also informed the constituent state medical associations of the need to emphasize general practice training and to ask these associations' members to encourage students to go into general practice.

Resolution #6 from the Essex County Medical Society, adopted by the 1964 House, called upon "the Board of Trustees to utilize all facilities at its command with deliberate speed to implement the intent of AMA Resolution #68;" and further required "that the Board report back to the 1965 House of Delegates what actions have been taken in the State of New Jersey and what progress has been made in the solution of this serious problem facing the American public, namely, the impending critical shortage of general practitioners to serve the public."

A special committee, appointed by the Board to implement the resolution, reported:

As viewed by the committee, two of the most cogent factors are: (1) the growing practice of many hospitals in insisting that staff members be specialty board men or board eligible; and (2) the fact that most medical schools neither have a Department of General Practice nor attempt in any way to stimulate students to become general practitioners.

One way that the hospital ban on G-Ps might be lightened derives from the statement by the Joint Commission on the Accreditation of Hospitals that "Arbitrary discrimination by hospitals against G-Ps is in direct conflict with the letter and spirit of principles of the Joint Commission."

Another question discussed was "would a three-year General Practice Residency Program and/or General Practice Boards help to insure hospital privileges, or would it just prolong the medical training program for all physicians and aggravate rather than relieve the current shortage of practicing physicians?"

Also considered were preceptor programs, such as are now in operation in 40 medical schools. Students and educators alike are enthusiastic about the value of preceptorships, especially in influencing young doctors of medicine to go into general practice or at least to recognize the existence and importance of general practice and general practitioners.

In discussing the many facets of the whole program of the G-P, the practice of medicine, and the image of the doctor as a whole, the committee stressed that it was extremely important for the family physician to respond to emergency calls, willingly to make routine house calls, and generally prove to the public that he is a very necessary—and perhaps the most important—member of the medical team.

* The importance of each county medical society's having a Future Physician's Club, headed if possible by an enthusiastic G-P, and the still greater importance of every physician's encouraging qualified young men and women to attend medical school cannot be overemphasized, the committee declares.

Emphasized

In a communication to Governor Hughes, the Board strongly presented its opinion that the public interest and the general good of the citizens of New Jersey demand that students in New Jersey medical schools be prepared for and guided into general practice rather than into the more limited fields of specialization and research.

The resolution "Training Family Doctors in New Jersey Medical Schools," adopted by the 1964 House of Delegates, was sent to the Governor and members of the New Jersey Senate and the Assembly, with the hope expressed that they join us in our effort to insure an increasing supply of family physicians to meet the expanding needs of the growing population of our State.

Approved (page 350), with emphasis on above paragraph*

MEDICAL SCHOOLS IN NEW JERSEY

(Reference Committee "D")

The report and conclusions of the Seton Hall Fact Finding Committee were studied and approved by the Board of Trustees, and the Committee members were commended for their sound judgment and forthright courage. A communication to the Governor, which was the subject of a press release, urged that the State take prompt and definite action to insure the continuation of the present Seton Hall school under State auspices, under whatever name may be selected. It likewise urged that the Rutgers University Medical School project be carried forward with unabated vigor. It was further stated that both schools, in the opinion of MSNJ, should be dedicated primarily to the production of practicing physicians rather than of research graduates. "Only in this way can the growing needs of our expanding population be met and professional medical care for all of our citizens be adequately supplied," the message concluded.

In reply, the Governor stated he was somewhat surprised that the Society appears to minimize the necessity of medical research in the State of New Jersey, and that as a layman, it was his view that research work is greatly responsible for the advances that practicing physicians are able to make in better protecting the health of all the people.

A statement in clarification of the Society's policy with reference to medical school programs in New Jersey was released to the newspapers, with copies to the Governor, legislators, and component societies. The letter to the Governor again emphasized the opinion that the great need in New Jersey is for an increased supply of practicing physicians and that this need should not be made secondary to any other objectives.

By invitation of Dr. Gross, President of Rutgers, members of the Board of Trustees and presidents of county societies met with representatives of the Rutgers University Medical School last November. The conference was called by Dr. Gross for the purpose of clarifying the Rutgers' position with reference to the medical school situation in New Jersey.

Approved (page 350)

NATIONAL EDUCATIONAL PROGRAM

(Reference Committee "E")

Last September the AMA outlined a "blueprint for national educational program on health care for the aged issue" scheduled to run during the month of October. Paid advertising in weekly and daily newspapers, magazines, television, radio, and pamphlets; speeches; posters; and news stories—all were to be used. The AMA stated that state and county societies would be required to effectuate the program locally. The AMA recommended that MSNJ determine what newspapers should be used to reach the maximum number of people. The entire project was examined by the Council on Public Relations, which unanimously recommended that MSNJ decline to participate in the program as "untimely and undesirable." The Board approved the recommendation and so notified the Board of Trustees of the AMA, pointing out the reasons why MSNJ rejected the program. A copy of the Board's letter to the AMA was supplied for the information of all the component societies of New Jersey and of the constituent associations of the AMA.

As a result of the Board's communication to the AMA, the President of the AMA requested a meeting of AMA and MSNJ representatives to discuss the program in depth. A special meeting of the Board was held in early

October, which was attended by the following representatives of the AMA: President, Chairman and Vice-Chairman of the Board of Trustees, Executive Vice-President, Assistant Vice-President, and Director of Communications Division. Following full and free discussion, the Board reaffirmed its decision not to participate in the Program.

The Essex and Hudson County Medical Societies commended the Board on its decision. The Ocean County Medical Society expressed dissatisfaction with the Board's decision, and the Bergen County Medical Society, in a resolution, urged MSNJ to support all the public educational programs of the AMA. With regard to this resolution, it was pointed out that it is the policy of the Board to support all programs which it regards as sound. The Board cannot consider itself bound to all programs without first discharging its duty of weighing programs in the best interest of MSNJ and its component societies.

The October-November 1964 *Membership News Letter* contained "A Ready Reference Questionnaire on the Kerr-Mills Law and Medicare." Additional copies were reprinted for distribution to members upon request.

The New Jersey delegation to the AMA introduced a resolution at the 1964 clinical meeting in Miami Beach: "Resolved, that—in the interest of unity of action and of the full and energetic support of national programs of this kind by all constituent associations, component societies, and individual members—in the future, the American Medical Association afford constitutent associations the opportunity of discussing and formally concurring in proposed national programs either by vote of their delegates at AMA meetings, or by vote of authorized representatives taken at special conferences held for that purpose." This resolution was dealt with by the Reference Committee on Legislation and Public Relations. In the course of lengthy discussion of this and other related resolutions, it was made clear that many state associations had found it difficult to work with the national educational advertising campaign as it was originally formulated; and in most instances had had to modify it according to local circumstances in order to participate in it at all. It was also made clear that the October national educational campaign would have greatly benefitted by more detailed and painstaking planning of a type that would invite and take cognizance of the suggestions of the constituent associations.

A special report from the AMA Board of Trustees stated: "The Board believes that the desire, expressed by several delegates at the hearing before the Reference Committee on Legislation and Public Relations, that the state societies be given an opportunity to participate in the planning of programs of this type is entirely reasonable."

The AMA House of Delegates strongly supported a proposed meeting of representatives of state societies to be held in Chicago on December 13, 1964 to discuss plans for an educational program relative to legislation. Dr. Donnelly, chairman of the New Jersey AMA Delegation, and Mr. Nevin, Executive Director, attended the meeting. Because of weather conditions, flights were cancelled and other New Jersey representatives were unable to attend. The conference concluded on a note of satisfaction in that the AMA representatives reported that they had benefitted greatly by the ideas and recommendations of the state representatives, and state representatives expressed pleasure in having had the opportunity to make constructive suggestions for the good of the program. The general expectation was that, in consequence of the planning conference, the forthcoming campaign would be marked by substantial agreement and effective cooperation.

A special conference of the AMA House of Delegates was held in Chicago in February to consider pertinent items relating to current national health legislation, including but not limited to health care for the needy and adequate support for the educational, scientific, and other programs of the AMA. The Board directed that the New Jersey delegation be not instructed concerning health legislation mat-

ters to be considered at the special meeting; that such matters be left for decision to the delegates and officers attending; but that the delegates be opposed to any increase in AMA dues which might be proposed. The House of Delegates gave unanmious support to the Herlong-Curtis Eldercare Bill (H. R. 3727) as embodying the basic principles of the AMA program. In response to a number of questions raised during the discussion, the delegates were told that the educational program would not require a dues increase or a special assessment.

Through an Ad Hoc Planning Committee for the 1965 AMA Educational Program, a local campaign titled "Operation Eldercare" was prepared. The committee enlisted the active cooperation of all members of MSNJ and the Auxiliary, the component societies and their auxiliaries, and cooperating agencies. More than 400,000 pieces of selected printed educational materials were supplied from the executive offices to members of MSNJ for use in contacts with their patients, to component societies, state and county auxiliaries, cooperating agencies, and the general public. The AMA has allocated to New Jersey for this program $16,660 on a matching basis. MSNJ expects to take partial advantage of this AMA grant.

Approved (page 351)

PRE-EMPLOYMENT PHYSICAL EXAMINATIONS

(Reference Committee "E")

The Sussex County resolution, adopted by the 1964 House of Delegates, urging MSNJ to develop and support the passage of amendments to existing law to require that pre-employment physical examinations (on persons under 18) should be performed "by either freely chosen or designated physicians," was referred by the Board to the Council on Legislation. The council drafted amending legislation embodying the directives of the resolution, which was approved by the Board and is now ready for introduction when earlier Society-sponsored legislation has been dealt with.

Approved (page 351)

STATEWIDE MEDICAL EXAMINERS' SYSTEM

(Reference Committee "E")

The 1963 House of Delegates went on record in favor of a change from the present county coroners' system to that of a unified, efficient, and complete statewide system of medical examiners. In furtherance of this action, a meeting under the auspices of the Council on Legislation was held in September to which each component society was invited. Fifteen component societies were represented at the meeting. A proposal for a statewide system was drafted. Governor Hughes was then informed that the Society is convinced, after investigation and study, of the need and desirability in New Jersey for a statewide medical examiners' system and the reasons therefor. In the protection of the public interest, the substitution of the statewide system for the present system of coroners and county physicians was urged, and request for a meeting was made. In reply the Governor assured the Society of his willingness to consider any such proposal. At his suggestion a copy of the proposed legislation was sent to the Governor's personal counsel for review and discussion with appropriate state officials. As soon as there has been departmental reaction to the proposal, a conference has been promised.

Approved (page 351)

AREA-WIDE PLANNING FOR HOSPITALS

(Reference Committee "F")

Last July, the Health Facilities Planning Council for New Jersey submitted a financial report on grants and estimate of resources, noting that it had applied for a federal grant. The Council expressed the hope that a contribution or pledge would be made by MSNJ. It was the action of the Board at that time to rely on the MSNJ representatives—Doctors Albright, McCall, and Wegryn—to make an official request if and when they deemed consideration of a financial contribution necessary and advisable.

In January the Board received a joint recommendation from its representatives on the

council that a contribution of $5,000, or a pledge in this amount, be made by MSNJ to support the council. They pointed out that unless a certain amount of money was obtained from contributions and pledges, the council would not receive a federal grant. It was the unanimous opinion of the Board that if MSNJ wishes to continue to have a strong voice in the deliberations of the council and looks for survival of the program, MSNJ must contribute a fair share toward the operating costs of this voluntary program. In consequence, the Board voted that a one-time contribution of $5,000 be given to the Health Facilities Planning Council for New Jersey.

It was suggested by the Council on Medical Services that it be given authorization to follow up on any problems on regional planning which come before the Society. Inasmuch as MSNJ is already represented on the council, the Board disapproved the suggestion, noting that the council is already progressing in the establishment of regional planning councils.

The resolution on Areawide Planning for Hospitals from the Essex County Medical Society, adopted as amended by the 1964 House of Delegates, was referred by the Board to the component societies, to the Council on Legislation, and to the Health Facilities Planning Council for New Jersey.

Approved (page 353)

RIGHTS OF PHYSICIANS IN HOSPITALS

(Reference Committee "F")

The New Jersey AMA delegation, at the direction of the 1964 House of Delegates, introduced and strongly supported a resolution on "Rights of Physicians in Hospitals" at the 1964 AMA annual meeting. This resolution was referred to the Reference Committee on Insurance and Medical Service. It called upon the AMA House of Delegates to affirm and support as basic and proper to physicians serving on hospital staffs: (1) the right of the active medical staff to elect its own officers; (2) the right of the active medical staff to review and revoke actions of its officers, committees, and members; (3) the right of the active medical staff to nominate and/or elect its chiefs of departments and divisions for submission to the hospital board of trustees for approval; and (4) the right of the active medical staff to formulate and revise its by-laws and rules and regulations. The reference committee declared that, in its opinion, "the intent of Resolution #50 is provided for in the Standards of the Joint Commission on Accreditation of Hospitals and in the current project (to develop recommendations on medical staff organization) of the Committee on Medical Facilities of the Council on Medical Service." The AMA House approved the recommendation of its reference committee to refer the resolution to the Council on Medical Service for consideration by its Committee on Medical Facilities.

Approved (page 353)

CIGARETTE SMOKING

(Reference Committee "G")

The 1964 House of Delegates adopted the following suggestion of Reference Committee "G:"

> . . . that the AMA be more positive in its approach to the cancer problem and smoking; and through state and local societies and individual physicians, carry its message to the public. Also, the harmful effects of smoking in conditions other than cancer should be emphasized; for example, in heart disease.

A resolution on the subject, embodying the points indicated, was introduced and strongly supported by the New Jersey delegation at the 1964 AMA annual meeting. It was one of about a dozen such resolutions.

The AMA reference committee offered a substitute statement (which the House adopted) which, in its view, encompassed the best points of the resolutions. The first paragraph of the statement is indicative of its general content. It reads:

> Having reviewed the actions of the House of Delegates of the American Medical Association, available printed information, and very excellent testimony, it became evident to your reference committee that the American Medical Association is on record and does recognize a significant relationship between cigarette smoking and the incidence of lung cancer and certain other diseases, and that cigarette smoking is a serious health hazard.

Approved (page 355)

DRUG ADDICTION PROBLEMS

(Reference Committee "G")

The resolution of the Middlesex County Medical Society, approved by the 1964 House of Delegates, called upon MSNJ (1) to engage in a statewide educational program in conjunction with our law enforcement agencies; (2) to formulate proper procedures for the treatment and follow-up care of addicts in conjunction with the Narcotic Drug Study Commission; and (3) to encourage the state legislature in demanding more stringent laws concerning people involved in the illegal sales of narcotics and drugs.

The first section of the resolution was referred by the Board to the Council on Public Relations and Legislation; the second section, to the Council on Public Health; and the third section, to the Council on Legislation. The progress on these referrals will be found in the reports of the respective councils.

Approved (page 355)

BICENTENNIAL CELEBRATION

(Reference Committee "H")

Rutgers—The State University will also celebrate its 200th anniversary in 1966. It was suggested that at least a portion of the celebrations of the 200th anniversaries of MSNJ and Rutgers be conducted in conjunction with the staff of Rutgers Medical School. Tentatively it is planned to hold a scientific meeting at the University on Saturday, October 1, 1966, which meeting will be sponsored jointly by Rutgers and MSNJ.

Approved (page 357)

AMA MEMBERSHIP OPINION POLL

(Reference Committee "H")

Resolution #8 from the Bergen County Medical Society, adopted by the 1964 House, called upon the AMA to poll the membership "on matters of great or even moderate importance that require no immediate decision." A resolution to accomplish this end was introduced and strongly supported by the New Jersey delegation at the 1964 AMA annual meeting. The resolution was referred to the AMA Reference Committee on Legislation and Public Relations. It stipulated that "in matters of great or even of moderate importance that require no immediate decision, the AMA membership be polled to obtain an expression of opinion . . . and that AMA delegates and trustees be guided by the result of such inquiry."

The House, on the recommendation of the reference committee, voted *not to adopt* the resolution (together with Resolution #6, which called for a poll concerning Social Security for self-employed physicians) for the reasons that "members of the House of Delegates express the majority sentiments of their constituents on all questions before this House" and "substitution of any other method of determining national policies would be subject to great error in that it presupposes equal knowledge on the part of all polled; that a slight majority of a limited response might be improperly interpreted as the weight of Association opinion; that it would create inflexible policy statements and would endanger the usefulness of the House of Delegates."

Received as information (page 357)

WOMAN'S AUXILIARY MEMBERSHIP

(Reference Committee "H")

The National Auxiliary proposed that membership of a physician in a county society include membership of his wife in the Woman's Auxiliary, thereby bringing the Auxiliary membership to an equal level with that of the Medical Society; and that the bill for both memberships be paid by the physician. The State Auxiliary recommended that this proposal be implemented in New Jersey.

The Board pointed out that it is not the policy of MSNJ to impose membership in the AMA on its members or those of the Society's Auxiliary, and declared that this same principle applies to county and state auxiliary membership.

Approved (page 357)

Secretary

Marcus H. Greifinger, M.D., Newark

(Reference Committee "A")

The office of the Secretary has continued its usual routines primarily involving correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year the Secretary attended the annual meeting of the American Medical Association in San Francisco and the Clinical Meeting in Miami Beach—serving in a dual role as the Secretary and an AMA Delegate. At state level, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(as of December 31, 1964)

Active: Paid	6,320	
Exempt	369	6,689*
Associate: Paid	423	
Exempt	38	461*
State Emeritus		153
State Honorary		5
New and Reinstated Members:		
Active	170	
Associate	243	413
Transfers within the state		27
Transfers out-of-state and resignations		47
Members deceased		81
Members dropped:		
Active (non-payment of dues)	28	
Associate (non-payment of dues)	12	

* Adjusted for Transfers Out-of-State, Resignations, and Deaths.

AMA MEMBERSHIP

As of December 31, 1964, the Circulation and Records Department of the American Medical Association reported that 6,039 members of The Medical Society of New Jersey were recorded as holding membership in the American Medical Association. As of that date, therefore, The Medical Society of New Jersey was assigned a total of seven delegates to the House of Delegates of the AMA, on the basis of one delegate for each thousand members or fraction thereof. It is a matter of satisfaction that MSNJ has now achieved its seventh AMA delegate.

MEMBERSHIP DIRECTORY

In November, 1964, it was a pleasure to announce the completion of the 1964-65 edition of the Membership Directory. Distribution to the entire membership was made shortly thereafter.

A number of new features were embodied in the new directory, including:

A special section—available only in the copies prepared for members—which supplies the Constitution and By-laws of MSNJ; the AMA Principles of Medical Ethics; the Legal Hazards of Medical Practice in New Jersey; and a list of Poison Control Centers in New Jersey.

In addition to the regular items carried in preceding editions, there are also a classification of members by counties and towns; a list of county medical society office addresses; a list of honorary members; identification of emeritus and associate members; and each member's New Jersey license number.

An expression of gratitude is in order for the cooperation received from the membership in producing this directory. The committee hopes that all members regard this edition as the most complete and serviceable version yet published.

Approved (page 344)

Treasurer

Daniel F. Featherston, M.D., Chairman, Asbury Park

(Reference Committee "B")

The administrative and fiscal year of MSNJ is June 1-May 31. The following financial report covers the business transactions in the office of the Treasurer for the past twelve months, representing transactions of one month in the fiscal year 1963-64 and eleven months in 1964-65—in accordance with the suggestion that the report cover twelve months even though two fiscal years are represented. This report, prepared and submitted by the auditor, covers the accounts from May 1, 1964, through April 30, 1965:

BALANCE SHEET — APRIL 30, 1965

ASSETS

Cash:		
First Trenton National Bank:		
General Checking Account	$53,918.80	
Executive Office Revolving Account	10,000.00	$ 63,918.80
Savings Accounts:		
The Bank of Commerce, Newark	$10,000.00	
Bloomfield Savings Bank, Bloomfield	10,000.00	
Broad National Bank, Newark	10,000.00	
First Camden National Bank and Trust Co.	10,000.00	
First Merchants National Bank, Asbury Park	10,000.00	
First National Bank of Stone Harbor	10,000.00	
First National Bank of Westville	10,000.00	
The Howard Savings Institution, Newark	10,000.00	
The Morris County Savings Bank, Morristown	10,000.00	
The Montclair Savings Bank, Montclair	10,000.00	
Plainfield Trust Company, Plainfield	10,000.00	110,000.00
Savings and Loan Accounts:		
Guardian Savings and Loan, Atlantic City	$10,000.00	
Midtown Savings and Loan, Newark	10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,000.00	
Roma Savings and Loan, Trenton	10,000.00	50,000.00
Total Cash		$223,918.80
Accounts Receivable		3,637.20
Inventory—Maternal Welfare Record Books (at cost) (contra)		1,887.50
Investments—U. S. Savings Bonds and Treasury Bills		183,527.56
Land, Buildings and Equipment (contra)		154,915.85
Accrued Interest on Investments		897.80
Total Assets		$568,784.71

LIABILITIES, RESERVES, AND SURPLUS

Accounts Payable	$ 4,516.25
Unexpended budget—1964–65 Fiscal Year	39,703.08
Employees Payroll Deductions Payable	1,871.77
Assessments Collected, Applicable to 1965–66 Fiscal Year	150,057.35
Bi-Centennial Fund	7,906.25
Library of Academy of Medicine Fund	7,906.25
AMA Dues	3,465.00
AMA Dues Collection	2,168.66
Annual Meeting Reserve	15,121.63
History Reserve—1966	6,489.15
Maternal Welfare Record Books Reserve (contra)	1,887.50
House Restoration and Replacement Reserve	4,541.92
Land, Buildings and Equipment Reserve (contra)	154,915.85
AMA Grant—Mental Health Congress Reserve	299.65
Surplus—April 30, 1965	167,934.40
Total Liabilities, Reserves and Surplus	$568,784.71

STATEMENT OF RECEIPTS AND DISBURSEMENTS

May 1, 1964 — April 30, 1965

RECEIPTS — GENERAL FUND

Cash Balance, May 1, 1964					$223,063.32
Assessments:	State Dues	AMA Dues	Special	Total	
Atlantic	$ 6,200.03	$ 6,435.00	$ 783.32	$ 13,418.35	
Bergen	29,646.91	24,592.50	3,800.78	58,040.19	
Burlington	5,733.40	5,760.00	738.31	12,231.71	
Camden	14,953.39	16,042.50	1,890.82	32,886.71	
Cape May	1,805.00	1,845.00	224.17	3,874.17	
Cumberland	3,813.38	3,555.00	488.31	7,856.69	
Essex	61,086.92	57,465.00	7,755.82	126,307.74	
Gloucester	2,993.34	3,285.00	375.83	6,654.17	
Hudson	22,506.69	21,870.00	2,828.34	47,205.03	
Hunterdon	2,126.70	2,115.00	279.16	4,520.86	
Mercer	18,493.44	19,620.00	2,346.63	40,460.07	
Middlesex	13,946.82	14,760.00	1,789.94	30,496.76	
Monmouth	13,240.08	10,845.00	1,696.67	25,781.75	
Morris	12,380.03	13,275.00	1,567.50	27,222.53	
Ocean	4,543.36	4,995.00	569.14	10,107.50	
Passaic	22,966.72	18,630.00	2,900.85	44,497.57	
Salem	1,640.00	1,845.00	205.00	3,690.00	
Somerset	4,260.02	4,455.00	544.17	9,259.19	
Sussex	763.34	675.00	90.00	1,528.34	
Union	23,753.47	25,380.00	3,035.83	52,169.30	
Warren	1,626.67	1,665.00	200.00	3,491.67	
AMA Refunds		765.00		765.00	
Total Assessments	$268,479.71	$259,875.00	$34,110.59	$562,465.30	
Journal Advertising and other Journal Income				$ 45,465.43	
Annual Meeting Exhibits				27,671.26	
Membership Directory Income				8,511.30	
Interest Income				9,094.71	
Sale of Maternal Welfare Books				1,081.25	
Refunds of Budget Expenses				4,420.87	
AMA Dues Collection				4,669.44	
Investments Redeemed (at cost)				147,973.48	
Payroll Deductions from Employees—net				581.19	
AMA Grant—Mental Health Congress				1,000.00	
Total Receipts					$ 812,934.23
Total					$1,035,997.55

DISBURSEMENTS — GENERAL FUND

Budget Accounts:		
A – 1 — Executive Salaries	$ 55,200.34	
A – 2 — Executive Office Salaries	58,364.02	
A – 3 — Executive Office Expenses	13,289.12	
A – 4 — Executive Travel	2,691.32	
A – 5 — House Maintenance	12,694.08	
A – 6 — Treasurer	3,707.17	
A – 7 — Finance and Budget Committee	36.30	
A – 8 — Secretary	885.11	
A – 9 — Salary Taxes	3,930.47	
A – 10 — Insurance	4,460.48	
A – 11 — House Reserve	20,492.42	
C – 2 — Council on Legislation	3,444.44	
C – 3 — Council on Public Health	1,641.62	
C – 4 — Council on Public Relations	4,878.94	
C – 5 — Council on Medical Services	19.60	
D – 1 — President and Presidential Officers	14,264.09	
D – 2 — AMA Delegates	9,943.23	
D – 3 — Woman's Auxiliary	4,529.34	
D – 4 — Committee on Medical Education	12.20	
D – 5 — Conference Groups	79.60	
D – 6 — Credentials, Membership, and Directory	25,789.55	
D – 7 — Disaster Medical Services	350.89	
D – 9 — Archives and History	21.50	
D – 11 — Medical Defense and Insurance	130.62	
E – 1 — Board of Trustees	4,741.37	
E – 2 — Contingent	13,620.77	
E – 3 — Judicial Council	218.45	
E – 4 — Legal	7,040.00	
E – 6 — Medical Student Loan Fund	5,000.00	
Total Budget Accounts		$271,477.04

Total Budget Accounts (Brought Forward)	$ 271,477.04
Journal Publication and Expenses	57,668.64
Annual Meeting Expenses	23,297.69
AMA Dues Remitted	256,500.00
Purchase of U. S. Treasury Bills	148,527.56
Special Assessments Remitted AMA-ERF	32,545.91
Transfers to Medical Student Loan Fund	16,633.60
AMA Grant—Mental Health Congress	700.35
Assessments Refunded	729.17
AMA Dues Collection	2,544.68
1966 History Reserve	1,010.85
Miscellaneous	443.26
Total Disbursements	$ 812,078.75
Cash Balance, April 30, 1965	$ 223,918.80
Total	$1,035,997.55

MEDICAL JOURNAL

(Cash Basis)

May 1, 1964 to April 30, 1965

Budget Appropriation for Salaries and Taxes (conra)*		$10,432.79
Cash Receipts:		
Advertising—State Medical Journal Advertising Bureau	$27,529.79	
Advertising—Classified	1,151.05	
Advertising—Local	10,508.75	
Subscriptions and Extra Copies	1,380.45	
State Medical Journal Advertising Bureau Rebate	1,674.12	
Abstracts and Reprints	1,540.37	
Decrease in Accounts Receivable	1,680.90	
Total Receipts		45,465.43
Total		$55,898.22

Cash Disbursements:		
Publication Costs	$41,042.17	
Journal Salaries (contra)	10,158.71	
Journal Office Expenses	313.19	
Journal Travel	107.21	
Discounts and Commissions—State Bureau	574.04	
Discounts—Local	96.17	
Commissions—Local	3,212.40	
Insurance	521.69	
Payroll Taxes (contra)	274.08	
Administrative Expenses—Local	1,368.98	
Total Disbursements		$57,668.64
Excess of Disbursements over Receipts		$ 1,770.42

* Disbursements include administrative salaries and taxes of $10,432.79 which were provided and paid from the General budget. They have been shown as expenses of the Journal operation in accordance with action of the 1963 House of Delegates. No transfer of funds has been made from the General Fund to the Journal operation.

Journal Accounts Receivable at April 30, 1965 total $3,637.20

MEDICAL STUDENT LOAN FUND

ASSETS

Cash:		
First Trenton National Bank		
Checking Account	$ 9,703.16	
Savings Account	10,000.00	
United Savings and Loan Association	10,000.00	
Total Cash		$ 29,703.16
U. S. Treasury Bills (at cost) due 6/30/65		28,953.00
Notes Receivable—156 Loans to 97 medical students		147,975.35
Accrued Interest on Investments		872.50
Fund Balance April 30, 1965		$207,504.01

The fund balance includes $6,302.00 designated as the A. Barker Kump Memorial Grant and $5,030.00 as the Joseph E. Mott Memorial Grant.

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

May 1, 1964 — April 30, 1965

Cash Balance, May 1, 1964		$ 54,346.96
Receipts:		
Budget appropriation from General Fund	$ 5,000.00	
Contributions—General	5,531.00	
Contributions—MSNJ Assessments	15,812.50	
Contributions—Joseph E. Mott Memorial Grant	3,600.00	
Contributions: A. Barker Kump Memorial Grant	250.00	
Interfund Transfer—General Fund	821.10	
Interest on Savings Accounts	543.38	
Collections of Notes Receivable	4,950.00	
Interest on Notes Receivable	145.22	
Annual Meeting Excess of Reserve	2,606.00	
Total Receipts		39,259.20
Total		$ 93,606.16
Disbursements:		
Loans to Medical Students—36 loans	$34,950.00	
Purchase of U. S. Treasury Bills	28,953.00	
Total Disbursements		63,903.00
Cash Balance, April 30, 1965		$ 29,703.16

Approved (page 346)

Judicial Council

E. Vernon Davis, M.D., Chairman, Camden

(Reference Committee "A")

This year the Judicial Council records with satisfaction the lowest total of complaints received since the establishment of the mechanism by the House of Delegates in 1950. Overall improvement in the statewide operation of the judicial mechanism has continued and perhaps in part accounts for the decrease in complaints.

From the official files, the Council presents the following resume of its operations and those of its county committees for the period extending from April 1, 1964 through March 31, 1965:

BY JUDICIAL COMMITTEES

Complaints reported as disposed of 30

Alleging:
- Dissatisfaction concerning fees 16
- Unprofessional conduct 2
- Unethical conduct 5
- Dissatisfaction with services rendered . 7

BY THE JUDICIAL COUNCIL

Meetings held 7
Official communications acted upon 18
Appeal hearings granted 1
Formal opinions rendered 4

Ethical acceptability of:

a. a physician's leasing office space for a percentage of gross income

b. a doctor of medicine's being the owner of a medical laboratory to serve patients other than his own

c. a member's authorizing a signed medical column in the weekly newspaper in his community

d. establishing a pharmacy within a clinic to dispense drugs

The foregoing opinions are presented in full as an appendix to this report, together with two other opinions which—by an oversight in the compilation of last year's annual report—were not published. They are now supplied for the continuity of the record.

Ethical acceptability of:

a. alleged solicitation of patients

b. a physician's requesting an advance payment for an agreed-upon surgical procedure

JUDICIAL COMMITTEES

During the past year, the Board of Trustees has had at least two occasions to point with satisfaction to the judicial mechanism as a means whereby differences and disagreements in the areas of ethical and professional conduct can be brought informally to a settlement that is fair to the interests of all parties.

In a press release issued in January, in answer to a request that the Society disclose the names of physician-members who own pharmacies or who are stockholders in drug repackaging firms, it was pointed out that MSNJ has no means of knowing how or where its physician-members invest their money. The statement declared: "It will and does, however, receive and process evidentially supported complaints of any violations of the standards of ethical medical practice . . . State and county medical societies are ready to inquire into the facts of a particular practice complained against as violating ethical principles and practices. The Medical Society of New Jersey maintains a judicial mechanism, in cooperation with its component medical societies, to process such complaints. It invites anyone with knowledge of such patient exploitation, who can document such charges, to submit a complaint in writing for processing under that mechanism."

In appeal to the members, urging their intensified and full cooperation in the maintenance of operationally adequate emergency call systems in all areas of the state, the Board pointed out that "the refusal of a member to serve in support of a component society's program, or failure to fulfill an assignment given, should result in the filing of a formal com-

plaint against the offending member before the judicial committee of his component society."

The Council reminds the membership that this mechanism is intended to demonstrate that within the family, as it were, Medicine can equitably and amicably settle its own problems in the areas of ethical and professional conduct. To accomplish this end, the mechanism is directly dependent upon the cooperation and good will of all members of the Society.

COMPONENT SOCIETIES

The Council has grown increasingly aware that, in certain instances, the constitution and bylaws of the component societies have not been kept up to date or maintained in conformity with the revisions of the constitution and bylaws of The Medical Society of New Jersey. In the interest of uniformity and conformity, the "Model Constitution and Bylaws" was issued to all component societies in 1963 with the approval of the Society.

The Judicial Council takes this occasion to urge that if component societies have not brought their constitution and bylaws into complete conformity with the regulations of the "Model Constitution and Bylaws," they do so without delay.

BYLAW AMENDMENT

In the course of the study involved in the revision of its "Regulations" last year, the Council discovered that Chapter VII, Section 7, of the Bylaws required revision in the interest of accuracy.

The Judicial Council of the American Medical Association entertains appeals from the findings of the judicial councils of constituent associations only when those appeals are submitted by members of the AMA. Accordingly, the Council has proposed that a correction of the Bylaws in this particular section be made.

A related revision indicating the time limits during which an appeal may be taken by a principal party to the AMA Judicial Council is also offered, to bring the Bylaws of MSNJ into conformity with the stipulations of the Judicial Council of the AMA.

The appropriate amendments were referred to the Committee on Revision of Constitution and Bylaws and to secretaries of component societies, in accordance with the provisions of Chapter XII of the Bylaws.

OPINIONS

ETHICAL ACCEPTABILITY OF A PHYSICIAN'S LEASING OFFICE SPACE FOR A PERCENTAGE OF GROSS INCOME

The Council unanimously declared that the practice is unethical, and cited the following opinion of the AMA in this regard:

"Office Space Rented for Percentage of Physician's Income Unethical. . . . The members of the Judicial Council do not favor an arrangement by virtue of which a physician leases office space for a percentage of gross income, believing it is violative of ethical principles. The practice indirectly results in fee splitting and tends to exploit the practice of medicine. If the size of a doctor's practice increases and imposes additional demands on the facilities of the building, these facts may be considered when the time comes to renegotiate the rental value of the leased premises, and a new fixed rental, taking these items into account, might be agreed upon. (Judicial Council, 1960)"

ETHICAL POSITION OF A DOCTOR OF MEDICINE'S BEING THE OWNER OF A MEDICAL LABORATORY TO SERVE PATIENTS OTHER THAN HIS OWN

It was the unanimous opinion of the Council that there is no transgression of any ethical principle if a doctor of medicine conducts a medical laboratory and serves patients other than his own, if those patients are referred to him by fellow-physicians.

ETHICAL PROPRIETY OF A MEMBER'S AUTHORIZING A SIGNED MEDICAL COLUMN IN THE WEEKLY NEWSPAPER IN HIS COMMUNITY

In considering this request, the Council made reference to the following opinion of the AMA Judicial Council:

"*Solicitation of Patients or Patronage.* . . . The Principles of Medical Ethics proscribe the solicitation of patients or patronage. Solicitation, as used in the Principles, means the attempt to obtain patients or patronage by persuasion or influence. However, the public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and the like. The doctor may ethically furnish this information through the accepted local media of communication, which are open to all physicians on like condition. Telephone listings, office signs, professional cards, dignified announcements, all are acceptable media of making factual information available to the public.

"The particular use to be made of any medium of communication and the extent of that use are, however, matters to be determined according to local ideals. What constitutes an excess, what is not in keeping with the ideals of medicine and what amounts to solicitation are questions of fact. The application of this principle is to be made locally.

"The propriety of the advertising practices of medical laboratories should be determined at the local level in compliance with this new opinion. (House of Delegates, 1962)"

It was the unanimous opinion of the Council that each case must separately be considered in the light of the section quoted. Final decision rests with the component medical society, which must decide whether or not the individual physician is acting within the scope laid down by the section; and in so doing is in no wise indulging in self-exploitation.

ETHICAL ACCEPTABILITY OF ESTABLISHING A PHARMACY WITHIN A CLINIC TO DISPENSE DRUGS

In discussing this request, the Council made reference to an earlier opinion (February 26, 1961) which it rendered under similar circumstances:

"*Ownership of Drugstores and Dispensing Drugs and Appliances by Physicians.* . . . It is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. This inadequacy must be confirmed by his component medical society. The same principle applies to physicians who dispense drugs or appliances. In both instances, the practice is unethical if secrecy and coercion are employed or if financial interest is placed above the quality of medical care. On the other hand, sometimes it may be advisable and even necessary for physicians to provide certain appliances or remedies without profit which patients can not procure from other sources.

"The Judicial Council unanimously agreed that in view of the above, determination of the ethical acceptability of the proposed procedure could only be made at county level. It therefore directed that the physician-member be guided by the opinion of the judicial committee of the component medical society of which he is a member. The county judicial committee has jurisdiction and authority in all questions involving ethical and professional conduct. (Chapter I, Section 8 of the former Principles of Medical Ethics of the AMA, which in greater detail discussed traditional positions encompassed in—but not explicitly dealt with—the revision of 1957)"

The Council also made reference to the following relevant opinions of the Judicial Council of the American Medical Association:

"*Ownership of Pharmacy by Physician.* . . . The Principles of Medical Ethics were revised in Atlantic City at the June 1955 Session of the House of Delegates to read as follows: 'It is not unethical for a physician to prescribe or supply drugs, remedies, or appliances as long as there is no exploitation of the patient.'

"Under this language, the Judicial Council does not believe it can be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient. (Judicial Council, 1957)"

"*Physicians Ownership of Drugstores, Drug Repackaging Houses and Pharmaceutical Companies and Dispensing of Glasses by Physicians.* . . . Section 7 of the Principles of Medical Ethics provides: 'Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.' Under this language it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

"It is unethical for a physician to have a financial interest in a drug repackaging company.

"It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine.

"These practices are contrary to the best interest of the public and the medical profession.

"The Council calls the attention of the House to the following statement concerning the meaning of the words 'drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient' which was adopted by the Council on June 26, 1958.

"It is the opinion of the Juicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patients. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done. On the other hand, this broad language provides a means by which a component medical society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense 'in the best interest of his patient;' it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income. (House of Delegates, 1963)"

In view of all the foregoing, it was the unanimous decision of the Council that only at local level can determination be made.

QUESTION OF ALLEGED SOLICITATION OF PATIENTS

In their consideration of this appeal, the Councilors agreed that the basic decision to be arrived at was to determine whether a letter in question falls into the category of ethical advertising or whether it goes beyond the limits of such advertising and falls into the category of solicitation of patients, which is unethical.

The Judicial Council of the American Medical Association (JAMA, March 30, 1957) declared:

"The Principles of Ethics do not proscribe advertising as such; they proscribe the solicitation of patients. Advertising, in its broad sense, means the act of making information, fact, or intention known to the public. Solicitation, as used in the Principles, means the attempt to obtain patients by persuasion or influence. Advertising, as distinguished from solicitation, is not in itself unethical."

In 1958 (September 28) the Judicial Council issued an opinion concerning the ethics involved in the following advertisements which had appeared in issues of *The Journal* of The Medical Society of New Jersey:

"Radiologist will interpret films taken in practitioners' offices. Reports telephoned immediately. Developing service, technical assistance, and pickup messenger service available.

"Fungus Diagnostic Services—Prompt determination of fungus disease from skin scrapings, blister tops, hair and nail clippings. Inquiries invited.

"In that opinion the MSNJ Judicial Council declared:

"In these instances there is no solicitation of the public involved since the advertisements are addressed only to fellow-physicians, appearing—as they do—in a medium intended exclusively for members of The Medical Society of New Jersey.

"Therefore, in light of the foregoing, it is the opinion of the Judicial Council of The Medical Society of New Jersey that the practice as reflected in the advertisements submitted for study does not violate the Principles of Medical Ethics of the American Medical Association, and, in consequence, is not unethical."

In 1962 (February 21) the Judicial Council rendered an opinion concerning the ethics involved in a letter issued by a hospital, over the signature of the hospital's administrator. It was directed to physician-staff-members announcing the hospital's willingness—under Rider J of Hospital Service Plan of New Jersey—to accept patients referred for diagnostic procedures.

In this matter, the Judicial Council declared:

"If the letter involved the direct solicitation of patients in the unethical sense which the Principles of Medical Ethics have been interpreted as prohibiting, the communication would have been addressed to the general public either by means of an announcement in the press or by some other media of general information. The fact that it was not would seem to be an indication that the hospital was mindful of this prohibition. As issued the letter was literally an official announcement to staff members of additional facilities and services available to them at the hospital in the care of their patients."

In 1953, the Council was called upon to evaluate the ethical status of a letter sent by two members of a county medical society to various personnel directors and business firms in the vicinity of their office. The Council concluded that in this instance, since the copies of the letter were sent not to physicians but to members of the public, they transgressed the limits of ethical acceptability as mere advertising and constituted in fact an attempt to build up the physicians' practice (in industrial medicine) by the direct solicitation of patients. The continued use of the letters was forbidden as unethical.

In the present matter the Council members found themselves called upon to decide whether a letter—sent by four physicians practicing in association, addressed to personnel directors of plants in the vicinity, announcing the opening of a new clinic, enumerating the services available and the hours of such availability, and inviting inspection of the clinic's facilities—was in fact a form of acceptable ethical advertising or a direct solicitation of patients.

The Council weighed well the fact that a physician is entitled to supply his patients with such information as is necessary for their convenient use of his professional services—information as to changes in location of his office, in his hours, etc.—but it also recognized

that a direct appeal to members of the public, of such a character as to influence or persuade them to utilize the professional services of those making such direct appeal, is in effect solicitation of patients and is ethically unacceptable.

The Judicial Council, by unanimous vote, found the subject letter in fact a letter of direct solicitation. As such it is ethically unacceptable and should be discontinued. The Council directed that its opinion be so rendered and that the contrary findings of the county medical society judicial committee be set aside.

The component societies of The Medical Society of New Jersey are free—and are encouraged—to approve the modes and forms of ethical advertising that may be used within their county borders. The fact that the Judicial Council has declared a form of advertising ethical does not obligate any component society to approve or make use of such ethical advertising locally. "The particular use to be made of any ethical advertising medium and the extent of that use are, however, matters to be determined according to local ideals" (Judicial Council, JAMA, March 30, 1957). Of course, such approved uses should be open to all member-physicians of the component society under like circumstances.

However, that which has been officially declared unethical by the Judicial Council of The Medical Society of New Jersey must thereafter be disapproved and forbidden by component societies of The Medical Society of New Jersey.

ETHICS INVOLVED IN PHYSICIAN'S REQUESTING AN ADVANCE PAYMENT FOR AN AGREED-UPON SURGICAL PROCEDURE

Of the AMA "Principles of Medical Ethics," only one specifically makes reference to the compensation of physicians. Section 7 declares:

"In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fees should be commensurate with the services rendered and the patient's ability to pay. . . ."

Obviously the question proposed involves a procedure to be done personally by the surgeon who collects a portion of his fee in advance. In the event that the surgeon does not himself supply the services as promised and agreed upon, under this section of the "Principles" he is obligated to return to the patient the entire amount of the pre-payment.

Section 1 of the "Principles" states:

"The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. . . ."

The Judicial Council does not regard this language as in any way preventing a physician or surgeon from taking steps to insure that fair and adequate compensation will be made to him by each patient financially able to supply such compensation, on any basis of payment mutually agreed upon.

The Council considers that negotiations concerning the method of schedule of payment of fees for the professional services to be rendered are properly entered into before the services are rendered rather than after. It is of the opinion that by this means misunderstandings and disagreements can be avoided. However, it is likewise of the opinion that no negotiations of this type should be permitted to interfere with the prompt performance of services necessary for the alleviation of acute conditions demanding immediate attention. The Council subscribes to and strongly supports the Society's official policy that "No one shall be denied necessary medical care because of inability to pay."

In the light of all the foregoing, it is the unanimous opinion of the Judicial Council of The Medical Society of New Jersey that in conjunction with elective procedures, under proper circumstances, it is not unethical for a physician to request an advance partial payment for the professional services which he is to render.

Approved (page 344)

Executive Director

Richard I. Nevin, Trenton

(Reference Committee "A")

Julius Caesar summed up an entire military campaign in probably the fewest words ever used in a formal report when he said: "I came; I saw; I conquered." His dictum has an appealing brevity, but unquestionably it falls far short of supplying any detailed information as to what actually occurred.

To sum up in satisfactory fashion what has transpired in a life, a year, or even an hour, is a challenging and difficult undertaking. The members of the House of Delegates each year receive some hundred pages of annual reports that collectively reflect the Society's activities in the year just completed, yet those reports do not tell the full story of the name and fame of The Medical Society of New Jersey. The full story would necessarily include a resume of every member's activities, because The Medical Society of New Jersey as a corporate entity is only a shadowy abstraction, and as a reality it lives and triumphs or fails through everything that all its members do or do not do. I shall not attempt a full report. That is already written in the hearts of our members, for them to read at will.

The year has been crowded with challenges and activities. As the science and art of Medicine grow in achievements and satisfactions, the status of Medicine perversely does not proportionately improve. This is largely attributable to political and economic pressures of such crushing and destructive potential as to be of menacing aspect to the peace of mind of the physician and to the future of his profession.

In the effort to fight off Medicare and to achieve instead the adoption of Eldercare, we of The Medical Society of New Jersey have all been intensely involved. Added work has been the lot of all—officers, members, and staff, and as of this moment the prospect of disappointed hopes and of bitter defeat looms. We shall, of course, follow closely the developments that ensue, and we shall hold ourselves ready to do whatever conviction and conscience indicate we must do for the welfare of the people and the good of the profession.

In other areas of Society activities, the developments have been less melancholy. The Board of Trustees, as is its wont, has met regularly and protractedly and has with judgment and vigor dealt painstakingly with the heavy volume of business before it. Our councils and committees have all faithfully and efficiently carried out their functions. The Council on Public Relations worked closely with the Board in encouraging and implementing throughout the state the national Eldercare campaign. The Council on Legislation naturally was part of this comprehensive effort, and at the same time it devoted itself assiduously to the routine of state legislative activities. In like manner, all the agencies of the Society applied themselves to their assignments and proper concerns with efficiency and benefit, as their individual reports will disclose.

It is a matter of satisfaction to all to note that *The Journal* has not only achieved new distinction of form and content, but that this year its operating deficit has been encouragingly reduced. It is a source of pride and satisfaction, too, that the 1964-65 *Membership Directory* has been so well received by our members and subscribers.

The year now ending has been a good year, by and large. In the nature of our work there is no possibility of simply initiating, pursuing, and completing neatly delimited undertakings. We are concerned with life—physical, mental, moral, social, economic, and political—and life is a continuing process involving constant change and adaptation, which cannot be packaged according to plans but must be dealt with on its own vigorous terms. The life of our Society, served on its own terms, has kept me

busy following and sharing in all the day-by-day operations of the Society. It has also involved me in a total of 169 meetings or conferences, in 8 meetings out of state, in 9 visits to component societies, and in 12 speech presentations. I report on my own activities for the information of the members; but in so doing, I want to point out that the activities and contributions of all of our officers, committee members, and staff have been equally heavy.

For long centuries Medicine has played a gladiator's role. In the arena of life it has done courageous battle against evils and dangers that threatened the health and well-being of men and women everywhere. Of this lineage are the men and women of Medicine descended. To this pattern of unselfish and aspiring effort they have been, and are, committed. It is important that we recognize that the greatness and nobility of the profession of Medicine have sprung from this very spirit of dedicated hostility to evils that Medicine perceives and is determined to overcome, and of dedicated devotion to the good that Medicine is determined to bring about. In this spirit we look to the past for inspiration, to the present for the worthy battles that are ours to fight, and to the future for such triumphs as we may win and such tests as will enable us to prove our enduring worth and our right to the title of "help-bringers to the world."

Approved (page 344)

Standing Committees

Annual Meeting

Edward E. Seidmon, M.D., Chairman, Plainfield

(Reference Committee "H")

Committee on the Annual Meeting met in June and again in September of 1964 with the Scientific Program Committee and the Scientific Exhibit Committee and officers of all specialty sections to arrange and finalize the scientific program for the 1965 annual meeting.

This year's program was arranged with exceedingly great care, including interesting subjects and topics most likely to attract the greatest attention and in keeping with a high calibre of medical instruction. The section officers and the chairmen of the Committees on Scientific Exhibit and Scientific Program are to be commended for their fine cooperation. The all-inclusive program provides a selection of papers on a wide-interest basis directed to all segments of the medical profession. Although arranged by specialty sections, the program, in substance and form, is specifically fashioned for the general practitioner. The papers and exhibits are well correlated and integrated toward this end.

The educational, scientific, and technical exhibits total 106. The latest and newest results in medical investigations are included in the scientific exhibits. Members are urged to visit the exhibits and to take advantage of the newest and latest information therein presented. The exhibits are an important educational part of the scientific sessions. We emphasize this fact this year as we have in previous years.

The 1965 Scientific Program will include about 65 scientific papers and some round-table discussions.

In cooperation with the New Jersey Academy of Medicine, the New Jersey State Department of Health, and the New Jersey State Department of Institutions and Agencies special scientific programs will be presented on Tuesday, May 18. A spread of three full days—Monday-Wednesday—will allow for fulltime presentation of all scientific papers.

As in previous years, the advance program was mailed early in February to all members so that they could make early arrangements to attend the annual meeting. The advance program was also mailed to hospitals in New Jersey, New York City, and Philadelphia; and to the medical societies of New York, Pennsylvania, Connecticut, Maryland, and Delaware. The committee extended an invitation to the membership of these neighboring societies indicating that there is no registration fee for out-of-state physicians who attend the MSNJ annual meeting.

For the Bicentennial Celebration in 1966, the 200th anniversary of our Society, tentative plans call for a scientific program on World Medicine and a General Session on World Affairs with outstanding speakers, and a Bicentennial Dinner with state and national dignitaries.

Because of the heavy convention schedule in Atlantic City each spring, it is advisable to set the annual meeting dates at least four years in advance in order to assure desirable dates and hotel accommodations. Haddon Hall is to enlarge its quarters to allow for more complete convention accommodations. The House of Delegates has already approved the following annual meeting dates which have been confirmed with Haddon Hall:

200th annual meeting — Saturday-Wednesday, May 14-18, 1966
201st annual meeting — Saturday-Wednesday, May 13-17, 1967
202nd annual meeting — Saturday-Wednesday, May 18-22, 1968

RECOMMENDATION

That the 203rd annual meeting be held at Haddon Hall, Atlantic City, Saturday-Wednesday, May 17-21, 1969.

Approved (page 356)

Subcommittees of the Annual Meeting Committee

Scientific Exhibits

Milton Ackerman, M.D., Chairman, Atlantic City

(Reference Committee "H")

The committee took the following actions during the year 1964-65:

1. Reviewed the content of past exhibits and instituted measures intended to improve the content and interest of the scientific exhibit. The major effort along these lines was by way of a letter addressed to department heads of all New Jersey, Philadelphia, and New York City hospitals and medical schools, and to the heads of research departments at Rutgers University, soliciting scientific exhibits for the

annual meeting. Approximately 1500 such letters were mailed.

2. Made a number of specific recommendations to the Committee on the Annual Meeting, dealing with methods of more thoroughly publicizing the scientific exhibit and bringing it to the attention of those attending the annual meeting.

3. Dropped the Motion Picture Theatre for the 1965 meeting due to continuing lack of interest in this portion of the meeting.

4. Reviewed applications for the 1965 Scientific Exhibits; selected and approved appropriate exhibits from among these applications; and appointed an Awards Committee to review the exhibits and designate awards.

Approved (page 356)

Scientific Program

Herschel S. Murphy, M.D., Chairman, Roselle

(Reference Committee "H")

A joint meeting of the Committee on Annual Meeting, the Subcommittee on Scientific Program, and the Section Officers was held on June 14, 1964. Plans were formulated for the various individual section and joint section meetings.

On September 27, 1964, a second meeting was held, at which time the scientific program, with the names of the speakers and their subjects, was discussed more fully. With the joint programs agreed upon, we will have twelve scientific sessions:

Joint programs:
- Allergy, Chest Diseases
- Anesthesiology, Cardiovascular Diseases
- Clinical Pathology, Urology
- Gastroenterology and Proctology, General Practice, Radiology, Surgery
- Obstetrics and Gynecology, Pediatrics, Psychiatry and Neurology

Individual programs:
- Dermatology
- Medicine
- Metabolism
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Rheumatism

There will be special programs on Drug Addiction and on Community Mental Health Centers—presented in cooperation with the New Jersey State Department of Health and the Division of Mental Health and Hospitals of the New Jersey State Department of Institutions and Agencies; on Perinatal Mortality and on Cancer Chemotherapy — presented in cooperation with The Academy of Medicine of New Jersey and the New Jersey State Department of Health.

We feel that the scientific sessions will offer to our entire membership programs which will appeal to their special interests.

We wish to congratulate the Section Officers on their selection of topics and speakers. All members of our Society are urged to attend the sessions of interest to them.

Approved (page 356)

Credentials

Marcus H. Greifinger, M.D., Chairman, Newark

(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the committee's activities during the period April 1, 1964 to April 1, 1965:

	Associate	Advancement to Active	Active	Total
Received	321	219	63	603
Reviewed and found:				
Satisfactory	278	203	56	537
Unsatisfactory	0	0	0	0
Pending	43	16	7	66

The committee again expresses appreciation to the officers of component societies for their cooperation.

Approved (page 344)

Finance and Budget

Carl N. Ware, M.D., Chairman, Ocean City

(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

THE JOURNAL

Although the Journal has experienced a decline in advertising of approximately 30% again this year through the State Medical Journal Advertising Bureau, this is the first complete year in which *The Journal* has had the benefit of the advertising rate increase of 65%—which became fully effective across the board as of March, 1964—and a smaller deficit is anticipated this year.

The anticipated deficit for publication of *The Journal*, editorial office expenses and travel, editor's insurance and salary taxes, assistant editor's salary taxes, and other journal expenses will be charged off to the unexpended balance in the budget accounts at the end of the fiscal year. This will result in a small net surplus in the 1964-65 total budget.

Approved (page 346)

SPECIAL PER CAPITA ASSESSMENT

For 1965, the 1964 House of Delegates voted a special per capita assessment of five dollars ($5.00) to serve as a contribution to the Medical Student Loan (50%), to the bicentennial fund (25%), and to the Library of the Academy of Medicine of New Jersey (25%)—to apply equally to all dues-paying members, with no reduction for associate members as in the past; and to be levied in addition to, and not as part of, the budgetary assessment, with

both being paid at the same time.

For 1966, your committee recommends that the House of Delegates vote a special per capita assessment of five dollars ($5.00) to serve as a contribution to the Medical Student Loan Fund (50%) to be available for loans in 1965-66, to the bicentennial fund (25%), and to the Library of the Academy of Medicine of New Jersey (25%). Your committee further recommends that that special per capita assessment apply equally to all dues-paying members, and that it be levied in addition to, and not as part of, the budgetary assessment, with both being paid at the same time.

Approved (page 346)

1966 ASSESSMENT

The computation of cash surplus at the close of the current fiscal year is estimated at $164,054.91—9% above the $150,000.00 sum which has been indicated as the desired surplus amount at the beginning of each new fiscal year.

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31 and the fiscal year is June 1 to May 31. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the per capita assessment to fiscal years on the basis of 7/12 for the new fiscal year soon to commence (June 1 through December 31, 1965) and 5/12 for the balance of that fiscal year (January 1 through May 31, 1966).

The proposed budget for 1965-66 is $253,623.00 . . . 7/12 of the 1965 assessment applicable to this proposed budget is $147,700.69. This leaves $105,922.31 to be raised by 5/12 of the 1966 assessment. On the basis of 6,240 paid members as of May 31, an assessment of $40.74 per capita will be necessary in 1966 to raise this amount (5/12 of $254,217.60 is $105,924.00). However, since the estimated cash surplus as of May 31 is $164,054.91 and the desired minimum cash surplus at the beginning of each fiscal year has been set at $150,000.00, the 1966 assessment can remain at $40.00 per capita by applying $1,922.31 from surplus toward the amount to be raised. ($105,922.31 less $1,922.31 leaves a net amount of $104,000.00 to be raised.) 6,240 members paid at $40.00 is $249,600.00—5/12 of which is $104,000.00. The net cash surplus at May 31 will then be $162,132.60.

1965-66 BUDGET

The proposed budget for 1965-66 totals $253,623.00. It is the opinion of the committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, the committee is listing explanatory footnotes on accounts showing a marked difference between current and proposed budgets.

RECOMMENDATIONS

1. That the budget for 1965-66 be adopted in the total sum of $253,623.00.

Approved (page 346)

2. That the 1966 assessment be adopted at $40.00 per capita, with no provision for a contribution to AMA-ERF.

Approved (page 346)

3. That the House of Delegates vote a special per capita assessment of five dollars ($5.00) to serve as a contribution to the Medical Student Loan Fund to be available for loans in 1965-66 (50%), to the bicentennial fund (25%), and to the Library of the Academy of Medicine of New Jersey (25%).

Approved (page 346)

4. That the special per capita level of contribution be set by the House in addition to and not as part of, the budgetary assessment, and that both be paid at the same time.

Approved (page 346)

ACCOUNT	Current 1964–65 Budget	Footnotes	Proposed 1965–66 Budget
A – 1 — Executive Salaries	$ 56,528.73	(1)	$ 58,501.73
B — Journal Salaries	11,758.93	(1) (2)	10,858.93
A – 2 — General Staff Salaries	59,118.84	(3)	62,616.92
A – 3 — Executive Office Expenses	13,515.00	(4)	14,000.00
A – 4 — Executive Travel	2,760.00	(5)	2,070.00
A – 5 — House Maintenance	13,479.00	(6)	16,000.00
A – 6 — Treasurer	3,780.00	(7)	4,170.00
A – 7 — Finance & Budget Committee	85.00		75.00
A – 8 — Secretary	1,050.00	(8)	1,300.00
A – 9 — Salary Taxes	3,455.00	(9)	4,185.42
A – 10 — Insurance	4,629.00	(9)	4,850.00
A – 11 — House Reserve	16,709.11*		5,600.00
C – 2 — Legislative Council	4,700.00	(10)	4,200.00
C – 3 — Public Health Council	2,100.00		2,200.00
C – 4 — Public Relations Council	7,160.00	(11)	6,800.00
C – 5 — Medical Services	700.00		700.00
D – 1 — President and Presidential Officers	10,420.00	(5)	8,850.00
D – 2 — AMA Delegates	9,370.00	(5)	4,620.00
D – 3 — Woman's Auxiliary	5,400.00	(5)	3,050.00
D – 4 — Medical Education Committee	135.00		100.00
D – 5 — Conference Groups	500.00		500.00
D – 6 — Credentials, Membership and Directory	9,105.00	(12)	8,400.00
D – 7 — Disaster Medical Care	150.00	(13)	325.00
D – 9 — Archives and History	100.00		100.00
D – 10 — Blood Bank Commission	250.00		250.00
D – 11 — Medical Defense & Insurance Comm.	300.00		300.00
E – 1 — Board of Trustees	4,750.00	(14)	5,200.00
E – 2 — Contingent	10,000.00		10,000.00
E – 3 — Judicial Council	500.00		500.00
E – 4 — Legal	8,300.00		8,300.00
E – 6 — Medical Student Loan Fund	5,000.00		5,000.00
Total	$265,808.61		$253,623.00

*1964–65 Budget appropriation $258,399.50 plus additional A-11 appropriation authorized by Board of Trustees, 9/20/64, $7,409.11 increasing the 1964–65 Budget to $265,808.61.

Approved (page 346)

FOOTNOTES FOR BUDGET

(1)—Increase due to salary increments to executive personnel authorized by the Board of Trustees.

(2)—Decreased due to elimination of the Contingent for extra help in the Journal–B–Account.

(3)—Increase due to merited increments granted for selected personnel in certain job classifications.

(4)—Increase due to additional office service expenses.

(5)—Decrease due to AMA Annual Meeting in New York and AMA Clinical Meeting in Philadelphia.

(6)—Increase in property tax and house supplies and services. Account provides for the purchase of a new house car.

(7)—Increase in per diem allowance for bookkeeping service.

(8)—Increase due to higher printing cost of the Annual Reports.

(9)—Increase due to change in Salary Tax rates and one additional employee to the permanent staff.

(10)—Reduction due to lower costs.

(11)—Reduction due to savings realized since the acquisition of a non-profit bulk rate mailing permit.

(12)—Allowance is made toward the 1966-67 edition of the Membership Directory.

(13)—Increase due to higher anticipated costs.

(14)—Increase due to higher specific board expenses.

Honorary Membership

F. Clyde Bowers, M.D., Chairman, Mendham

(Reference Committee "H")

No nominations were submitted to the Committee on Honorary Membership. Consequently, no meetings of this committee were held during this administrative year.

Approved (page 356)

Medical Defense and Insurance

Daniel F. Featherston, M.D., Chairman, Asbury Park

(Reference Committee "D")

During the year, 1964-65, the Committee on Medical Defense and Insurance met twice with full attendance at one meeting and with only one absentee (who was in Europe) at the other.

The committee continues to be completely satisfied with the interest and cooperation of the present official carriers of the various insurance programs sponsored by MSNJ for its members.

PROFESSIONAL LIABILITY

The activity and results in this area of experience are best shown by the following tables supplied by the American Mutual Liability Insurance Company from its records.

The Loss Control Program continues to show promise toward the reduction of losses. However, the company is, as yet, unwilling to commit itself to an experience rating for New Jersey because of insufficient data of completed cases at this time. It has, however, assured us that it should be able to establish an experience rating by the end of the 1965 premium year.

Suits filed (11/1/60–3/1/65)		342
Suits disposed of to 3/1/65		106
Plaintiff verdicts	0	
Defendant verdicts	14	
Voluntary dismissal, etc	50	
Settled	42	
Participation in program as of 3/1/65:		
Eligible physicians	6,946	100%
Insured physicians	3,799	55%

	Insured Physicians	Reported Incidents	Suits
Policies effective 11/1/60	1,860	114	65
Policies effective 11/1/61	3,372	336	172
Policies effective 11/1/62	3,623	243	76
Three year totals	8,855	693	313
(Per 100 insured physicians)		(7.8)	(3.4)
Policies effective 11/1/63		176	29
Policies effective 11/1/64		27	
Five year totals		896	342

ACCIDENT AND HEALTH

We have had another satisfactory year in the administration of the accident and health insurance plans with policies in the National Casualty Company and in the Nationwide Mutual Insurance Company. Each of these plans provides monthly benefits up to $600 for basic coverage and up to $600 for extended coverage. Approximately 3,900 of our members hold basic accident and health policies in the National Casualty Company and 2,300 of our members have added the extended coverage. Under the Nationwide program there are approximately 3,000 of our members with basic policies, and 142 of them have added the extended coverage.

The National Casualty Company has paid in excess of $400,000 of disability claim benefits to 401 doctors, with the highest amount paid to one doctor in the sum of $8,100. Under the Nationwide accident and health program approximately $140,000 in disability benefits were paid to 290 claimants, with the highest amount paid to one doctor in the sum of $5,000.

MAJOR MEDICAL EXPENSE

This policy with the National Casualty Company continues to serve 2,800 members. In excess of $150,000 has been paid in claims to 150 claimants—members and/or dependents—insured under this policy during the past year, with two maximum $10,000 claims having been paid. Since March 1, 1964, when the special provision went into effect to permit the continuation of major medical insurance for widows of deceased member-policyholders, twelve widows have taken advantage of this coverage.

Claim costs under this form of insurance are still on the rise because major medical costs

follow constantly rising hospital costs.

HIGH-LIMIT ACCIDENT

The high-limit accident policy of the Nationwide Mutual Insurance Company provides accidental death benefit and total disability coverage up to $200,000 for the member and up to $100,000 for the spouse at a premium of $1.00 per $1,000 for the member and 60¢ per $1,000 for the spouse. The plan is now in effect with 510 of our members. We are pleased to state that no claims have as yet been presented under this policy.

LIFE

Approximately 1,850 of our members are insured under this plan with approximately 2,100 $10,000 Five Year Renewable and Convertible Term Life Policies in force, and approximately 400 policies converted in the past year to standard forms of life insurance. The first of these policies went into effect in 1959, and the year 1964 saw the end of the first five-year renewal period. Many continued the five year renewable term form of insurance, and approximately 400 members converted one or more of their policy units to a standard form of life insurance—a privilege of the insurance program which does not require medical examination.

During the twelve month period ending March 12, 1965, there were fourteen death claims—nine subjects of which were impaired risks when insured. It is to be noted that when this life policy was put into effect in 1959, impaired risks were allowed $10,000 policies by virtue of the privileges of the enrollment at that time. Of the fourteen claims presented, thirteen have been paid for a total of $125,000, with one death claim still pending at the date of this report. Eighty-three death claims were paid under this program since its inception in 1959. Of the eighty-three death claims, sixty-one came from the impaired risk category referred to above.

APPRECIATION

The committe wishes to express its thanks to Mr. Joseph A. Britton, New Jersey Manager for the American Mutual Liability Insurance Company; and to Mr. William Blanksteen, of the E. & W. Blanksteen Agency, for their continued cooperation and attendance at our meetings when requested.

The chairman wishes to thank each committee member: Doctors Fred A. Mettler, Ernest C. Hillman, Jr., Benjamin F. Slobodien, Elton W. Lance, and William L. Palazzo. Appreciation is extended to our Executive Director, Richard I. Nevin; our Administrative Secretary, Edith L. Madden; and our Counsel, Robert M. Backes, for their assistance and guidance in our deliberations.

RECOMMENDATIONS

1. That the American Mutual Liability Insurance Company be continued as the officially designated carrier for our professional liability insurance program.

2. That the E. & W. Blanksteen Agency be continued as the official broker for our accident and health, high-limit accident, major medical, and life insurance programs.

Approved (page 349)

1964 TRANSACTIONS

At its first session on Saturday afternoon, May 15, 1965, the House of Delegates:

Approved the Transactions of the 1964 House of Delegates as published in the July 1964 issue of THE JOURNAL and distributed to the membership.

Medical Education

Sherman Garrison, M.D., Chairman, Bridgeton
(Reference Committee "D")

In response to the committee's request last spring that questionnaires be sent to all interns, residents, and house officers in all New Jersey hospitals, the Board of Trustees was of the opinion that the end would not justify the means and would probably not accomplish the intent of the committee. Following further review and study, the committee felt that such a questionnaire would be of some help toward the solution of the problems in this area. However, the Board reaffirmed its previous action and disapproved the proposal to mail such questionnaire.

The committee calls attention to the study currently in progress by the Academy of Medicine to evaluate medical education programs in New Jersey.

It is recognized that New Jersey is unusually fortunate in the variety and depth of medical education programs available to the members of our Society. The committee feels that more coordination of these programs is desirable and that this coordination should be carried on outside this Society, probably by the Academy of Medicine.

Though maintaining an active interest in continuing medical education, the committee feels that there is very little action available within the province available to the Board of Trustees, county societies, or community hospitals in considering any matters in this field of concern to these parties.

Accepted (page 349)

Medical Student Loan Fund

Luke A. Mulligan, M.D., Chairman, Leonia
(Reference Committee "B")

In its eight years of operation, the Medical Student Loan Fund has granted a total of $157,275.35 in 164 loans to 102 New Jersey medical students. Eight loans have been repaid in full and seven loans are being repaid.

Requests for financial assistance by New Jersey medical students are increasing each year; and if we are to continue our loan program, the Fund must have more money. The 1964 House of Delegates adopted a $5 per capita assessment, 50% of which was to serve as a contribution to the Medical Student Loan Fund, to be used for loans in 1964-65. For the 1965-66 school year, it is estimated that we will have approximately $19,000 available for loans, which is $15,450 short of the total loans granted in 1964-65. There are 20 students (who will be juniors and seniors in 1965-66) who received loans this year and who, undoubtedly, will apply for loans next year.

Early this year the regulations governing loans were amended by the addition of the following section:

> This Fund is made available to encourage medical education as well as internship and medical practice in the State of New Jersey. It is suggested that each student consider his application in this light and if approved, accept the loan on these terms. In the event a borrower terminates his medical school education, voluntarily or involuntarily, or interns, or practices outside of the State of New Jersey, his obligation to repay the funds borrowed will be immediately accelerated.

The financial activities of the Fund during the year are included in the report of the Treasurer.

DISTRIBUTION OF LOANS

County of Residence	*Medical School*	*Students*	*Loans Granted*	
			1957–1964	*1964–1965*
Atlantic	Hahnemann	1	$ 1,000.00	$
	N. J. Medical	1	1,000.00	
	Pittsburgh	1	2,000.00	
	Tufts	1	2,000.00	1,000.00
Bergen	Boston	1		1,000.00
	Hahnemann	1	3,000.00	
	N. J. Medical	7	7,000.00	2,000.00
	N. Y. Medical	1		1,000.00
	St. Louis	1	500.00	1,000.00
	Woman's Medical	1	1,000.00	
Burlington	Duke	1	3,000.00	1,000.00
	Jefferson	1	2,000.00	
Camden	Jefferson	2	1,000.00	1,000.00
	Michigan	1	2,000.00	
	N. J. Medical	2	2,750.00*	
	Temple	3	2,500.00	1,000.00
Cumberland	Jefferson	1	2,000.00	
Essex	Albany	1	1,000.00	1,000.00
	Bern	1	2,325.35*	
	Duke	1	1,000.00	1,000.00
	Hahnemann	1	1,000.00	1,000.00
	Howard	1	300.00	
	N. J. Medical	6	9,800.00	1,850.00
	N. Y. Medical	2	1,000.00	1,000.00
	St. Louis	1	500.00	
	Temple	1	1,000.00	
Gloucester	Temple	1	2,000.00	
	Hahnemann	1		600.00
Hudson	Harvard	1	1,000.00	
	Howard	1	400.00	
	N. J. Medical	14	17,500.00	2,000.00
	N. Y. Medical	1	1,000.00	
	Pittsburgh	1		1,000.00
	St. Louis	1	2,000.00	
Mercer	Hahnemann	2	3,000.00	
	Howard	1	1,000.00	
	Johns Hopkins	1		1,000.00
	Meharry	1	250.00	
	Mississippi	1	2,000.00	1,000.00
	N. J. Medical	3	6,000.00	1,000.00
	Pennsylvania	1	1,000.00	
	St. Louis	1	700.00	
Middlesex	Georgetown	1	500.00	1,000.00
	Hahnemann	1	1,000.00	1,000.00
Monmouth	Columbia	1	1,000.00	1,000.00
	Jefferson	1	1,000.00	1,000.00
	N. J. Medical	2	3,000.00	1,000.00
	N. Y. Medical	1	1,000.00	1,000.00
	Temple	1	2,000.00	
	Up-State N. Y.	1	1,000.00	
Morris	Dartmouth	1	1,000.00	
	Duke	1		1,000.00
	N. J. Medical	1	2,000.00	1,000.00
Passaic	Jefferson	1	1,000.00	1,000.00
	N. Y. Medical	1	1,000.00	
Somerset	N. Y. Medical	1	2,000.00	
	Temple	1	3,000.00	
	Western Reserve	1	1,000.00	
Union	Hahnemann	1	1,000.00	
	N. J. Medical	9	11,800.00	3,000.00
	Florida	1		1,000.00
15 Counties	25 Medical Schools	102	$122,825.35*	$34,450.00
				($157,275.35*)

(*Includes payment of insurance premiums.)

CONTRIBUTIONS

The committee is grateful to the many contributors to the Fund and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

Albert Barker Kump Memorial Grant
Dr. Joseph R. Jehl in memory of Mrs. David B. Allman.

Joseph E. Mott Memorial Grant
Passaic County Polio Immunization Committee.

General Fund

The Medical Society of New Jersey, Board of Trustees, AMA Delegates; County Societies: Burlington, Hudson, Mercer, and Salem.

State Auxiliary Executive Board, Fellowettes; County Auxiliaries: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Union, and Warren.

Mrs. Anthony Ambrose, Mrs. Robert G. Bloomer, Mrs. Walter S. Booth, Dr. and Mrs. Jules Cooper, Dr. and Mrs. Millard Cryder, Dr. and Mrs. Floyd D. Gindhart, Dr. and Mrs. Rubin Grossman, Dr. Joseph R. Jehl, Dr. and Mrs. Paul B. Jennings, Dr. and Mrs. John F. Kustrup, Dr. and Mrs. Albert Lepis, Dr. and Mrs. Samuel J. Lloyd, Dr. and Mrs. B. J. Macchia, Mr. and Mrs. John T. Madden, Mr. and Mrs. Harry A. Margolis, Dr. and Mrs. Luke A. Mulligan, Dr. and Mrs. Paul H. Pettit, Dr. and Mrs. Paul E. Rauschenbach, Mrs. Kate Rosenthal, Mrs. Marie Tsucalas and Sons, Dr. and Mrs. Chester I. Ulmer, Mrs. H. Roy Van Ness.

In memory of:

Mrs. David B. Allman, Mrs. Robert C. Anderson, Mrs. Michael Androulaskis, Mrs. John E. Barber, Robert T. Brown, Mrs. Loretta Carey, Peter Collins, Henry A. Connolly, Mrs. George F. Corrigan, Terry Dangles, Armand Dodsworth, Dr. W. B. Ellison, Ira Farber, Harry Feit, Richard B. Fox, Sr., Nial P. Gardner, Sr., Dr. Harry M. Gochman, Dr. Karl Goldstone, Dr. William Hilliard, Mrs. Benjamin Jennings, Dr. Harry P. Kane, David Kaplan, Mrs. John S. Klinger, Dr. Philip Kresch, Thomas Lee, Mrs. Elizabeth J. Lockey, Mrs. Geraldine MacLaren, Humbert J. Martoccio, Dr. Paul B. Means, Dr. Emma W. Metzer, Mrs. G. Paxson Murphy, S. Jay Myers, Dr. Frank Perry, Mrs. Rachael Poley, Dr. Louis A. Pyle, Robert Ramsey, Mrs. Nan Rednor, Mrs. Charles F. Richards, Dr. E. Warren Rodman, Dr. Anthony G. Sacco, Mrs. Emanuel M. Satulsky, Dr. Royal A. Schaaf, Dr. R. Louis Silverman, Floyd Simms, John Solomon, Dr. Norman A. Welch, and Dr. John M. Wetherhold.

In honor of:

Dr. Edwin H. Albano, Dr. Charles W. Barkhorn, Dr. Millard Cryder, Mrs. Wilbur S. Davison, and Dr. Francis C. Weber.

RECOMMENDATIONS

1. That the House of Delegates appropriate monies to the Fund to be used for loans in 1965-66;

2. That the membership be urged to send contributions to the Fund; and

3. That the Woman's Auxiliary again be requested to make the Fund its number one project during the forthcoming year.

Approved (page 347)

Publication

George B. Sharbaugh, M.D., Chairman, Trenton

(Reference Committee "B")

You like *The Journal!* As a matter of fact, you prefer it to other publications. The January 1965 issue gave every member a chance to voice his comments, criticisms, and suggestions about *The Journal* and its contents. The reply postcard questionnaire was short and the results were sweet. People are more likely to be articulate about their gripes and remain silent if they have no complaints. We assume, therefore, that those who did not register their complaints had none important enough to write home about. We are grateful to those who took the time and trouble to make comment.

The nature and proportionate content of *The Journal* will continue to be predicated upon membership opinion tinctured by the economic realities.

NEW PRINTER

Toward the end of 1964, the committee was faced with a substantial increase in printing costs. As a result, it re-negotiated with Printing Corporation of America—which had expressed continuing interest in printing *The Journal* and had renewed its original proposal from time to time throughout the year. With the approval of the Board, Printing Corporation of America was awarded a three-year contract—effective with the March 1965 issue. Its extensive facilities will help us greatly in the production of a better journal and in the battle with ever-mounting costs.

SIZE OF JOURNAL

With the March issue, the size of *The Journal* was changed slightly to conform with the average size of other state medical journals. It is now a standard 8 x 11.

JOURNAL CONTENT

Evidence continues to accumulate that *The Journal* is becoming better and better known. Many original articles have attracted interest all over the country. Dr. Davidson's editorials have aroused considerable interest and are frequently quoted—and sometimes reprinted in full—by other periodicals. This popularity is shared by the members, who overwhelmingly voted them their "most liked" *Journal* feature in the readership survey.

To remain within our budget, we were obliged to reduce text matter. The committee is sensitive to the need for a balanced intellectual diet and regrets the reduction of space available for scientific articles. But *The Journal* deficit had to be offset by the economy of smaller size. Now that the financial crisis seems to be over, the committee hopes to reestablish the desired balance by publishing more scientific material.

We are proud of the expansion of our book review department. Publishers have manifested an eager interest in our reviews—even the unfavorable ones.

A tabular comparison of material in *The Journal* for the last four years is here presented:

	1961	1962	1963	1964
Book Reviews	33	28	21	34
County Society Reports	25	25	—	—
Editorials	34	36	28	24
Historical Material	6	—	—	—
Letters and Announcements	19	28	15	11
Original Articles	255	238	279	255
Psychosomatic Profiles	—	4	6	—
State Activities*	240	263	209	206
Total of text material	612	622	558	530
Advertising	844	781	620	482
Grand total of pages	1456	1403	1178	1012
Ratio: advertising/text	56%	55.6%	53%	52%

*Includes obituaries.

FINANCIAL PICTURE

The Journal is now beginning to see the results of the financial changes initiated three years ago. A conspicuous decline in journal advertising throughout the country continues to be a feature in the budgets of most pharmaceutical companies. Despite the reduced pages of advertising (as reflected above in the tabular comparison), *The Journal* has managed to reduce its operating deficit by several thousand dollars: the advertising income is up over last year and the publication costs are down. With the exception of salaries, *The Journal* is once again on the way toward paying for itself. It is not—and never has been—the function of *The Journal* to make money. But the committee is ever aware of your desire to maintain *The Journal* on a sound economic basis. If advertising falls off, we hope to balance this by continued prudent management and a proportionate reduction in text material.

The financial statement covering *The Journal* is reflected in the annual report of the Treasurer.

JOURNAL ADVERTISERS

The Journal is, of course, a cooperative venture. We owe thanks to our advertising representatives for bringing in the advertisements that provide the financial fuel for *The Journal.* Our advertisers are partners with you in its development. We could, of course, put out a *Journal* without the help of the advertisers. But this would not only skyrocket the costs, it would also deprive you of much of the color and instruction that characterize *The Journal.* Our advertising pages are not simply bill-posters huckstering commercial products. They are, in truth, portable bulletin boards of what's new in medicine. So we urge you to look through our advertising section—not as a tour through a commercial display, but as a swift graduate course telling you what's new in medicine.

The Journal has thus continued as an effective organ for our Society and as a compact graduate text for the doctors of New Jersey. It also serves as an instrument of communication between the officers and the members of the Society, as a record of the contributions which New Jersey has made on both the scientific and economic fronts, and as—we hope—a not unworthy ambassador for the Society to all of the other state medical societies in the country.

Approved (page 346)

Revision of Constitution and Bylaws

Louis F. Albright, M.D., Chairman, Spring Lake

(Reference Committee on Constitution and Bylaws)

The following proposed amendments to the Bylaws, as submitted by the Judicial Council, were transmitted to the secretaries of component societies and to the Committee on Revision of Constitution and Bylaws under date of February 1, 1965—in accordance with the provisions of Chapter XII of the Bylaws.

The committee found the amendments to be in proper form for submission to the House of Delegates. The amendments have the approval of the Committee on Revision of Constitution and Bylaws.

In the course of the study involved in the revision of the "Regulations," the Judicial Council discovered that Chapter VII, Section 7, of the Bylaws required revision in the interest of accuracy.

The Judicial Council of the AMA entertains appeals from the findings of the Judicial Councils of constituent associations only when those appeals are submitted by members of the AMA. Accordingly, the Judicial Council proposes that a correction of the Bylaws in this particular section be made.

A related revision indicating the time limits during which an appeal may be taken by a principal party to the AMA Judicial Council is also offered, to bring the Bylaws of MSNJ into conformity with the stipulations of the Judicial Council of the AMA.

Adopted (page 358)

CHAPTER VII—JUDICIAL COUNCIL
SECTION 7—APPEALS

Current

Any member of a component society aggrieved by an action of the county judicial committee, or any applicant for membership who has been excluded from membership by a county society, or any lay person aggrieved by an action of the county judicial committee may appeal from the decision or action of the county society or the county judicial committee judicial committee to the Judicial Council

Decision of the said Judicial Council in any matter so appealed shall be final, except that further appeal may be taken by either party to the Judicial Council of the American Medical Association, if the subject of the dispute falls within the jurisdiction of that Council.

Any appeal to the Judicial Council of The Medical Society of New Jersey must be filed with the Judicial Council within forty-five (45) days of the date of the formal notice to the aggrieved party of the action of the component society or of the county judicial committee.

Form of notice of appeal and procedure in hearing and adjudication of same shall be in accordance with rules

of procedure to be established by the Judicial Council, which shall be made available to the parties involved.

Upon filing a notice of appeal, the appellant and the component society or county judicial committee will be required to submit to the Judicial Council all records and papers relative to the matter under appeal. All such papers shall be treated confidentially by the Judicial Council and shall be returned at the completion of the hearing.

The Judicial Council may affirm, modify, or reverse, by a majority vote of its members present and voting, the appealed decision. The Judicial Council may summon witnesses, take new evidence, and investigate the appealed matter in any manner in its opinion required to develop the information necessary for a proper decision.

Proposed

Decision of the said Judicial Council in any matter so appealed shall be final, except that further appeal may be taken by *a principal who is a member of the American Medical Association* to the Judicial Council of the American Medical Association, if the subject of the dispute falls within the jurisdiction of that Council.

Adopted (page 358)

Any appeal to the Judicial Council of the American Medical Association must be filed within thirty (30) days of the date of the decision of the Judicial Council of The Medical Society of New Jersey, and the appeal shall be perfected within sixty (60) days thereof, although for good and sufficient cause an additional thirty (30) days may be granted for perfecting the appeal.

Adopted (page 358)

Woman's Auxiliary

George O. Rowohlt, M.D., Chairman, Dumont

(Reference Committee "H")

The official programs and projects of the Woman's Auxiliary were submitted and approved by the Board of Trustees.

This year the Advisory Committee wishes to delineate more didactically the varied activities of the Auxiliary. Most county auxiliaries have conducted excellent public relations programs, such as health forums, public relation days, health fairs, informational panels, community service teas, and other meetings open to the public. Through the schools many county auxiliaries have sponsored nurse recruitment programs, allied health career programs, and future nurses clubs. Most county auxiliaries have given nurses' scholarships or have sponsored a loan program. In the field of community service, auxiliaries aided their county societies in eye screening programs, Sabin oral poliomyelitis vaccine programs, and diabetes detection drives. They have worked with Mental Health Associations and county Homemaker Service Agencies. The MSNJ Auxiliary also supported the theme of the National Auxiliary, "Better Health—Better World." The State International Health Activities Program has increased its pace in collecting and dispatching drug samples, equipment, books, etc. to deserving communities in many parts of the world.

In addition to these activities, the Auxiliary has continued to help support The Medical Society of New Jersey—its parent organization—in many projects and programs throughout the year, notably the Eldercare Program, Future Physicians' Clubs, Medical Student Loan Fund, and Committees on Medicine and Religion.

As well as increasing its over-all membership, the State Auxiliary has been happy officially to welcome the Morris County Medical Society's Auxiliary into the State organization. This year we are happy to report that the Sussex County Medical Society has given its approval for the formation of the twenty-first and last county auxiliary in our State. At last state unity has been achieved, and we look forward to the participation of Sussex County Auxiliary in the organization.

Amended to read: This year we are happy to report that the Sussex County Medical Society IS CONTEMPLATING its approval for the formation of the twenty-first and last county auxiliary in our State AND HAS SCHEDULED FINAL DECISION ON THIS AT ITS JUNE MEETING.

The Advisory Committee wishes to thank, congratulate, and commend the officers and members of the Auxiliary for their diligence, efficiency, and cooperation in helping to promote purposes and programs of The Medical Society of New Jersey and in furthering the health and welfare of the people of the State of New Jersey.

Approved as amended (page 357)

Legislation

Jesse McCall, M.D., Chairman, Newton

(Reference Committee "E")

In reporting to the House each year, attention is called to the fact that, while the Society is reporting on a full administrative year, the Council on Legislation necessarily is accounting for the activties of two legislative calendar years: those items acted upon by the Legislature before final adjournment in 1964 and other legislative items introduced since the beginning of the 1965 session which continue to be of interest and concern to the council. The legislative year begins with the second week of January, and it continues until the date agreed upon by both houses for their *sine die* adjournment the following year.

1964 LEGISLATIVE SUMMARY

At noon on January 11, the 188th session (1964) of the New Jersey Legislature adjourned *sine die*. During that session a grand total of 1,340 pieces of legislation were introduced. The Council on Legislation gave detailed study to 120 measures as relevant to the Society's interests and concerns. As the result of this session, sixteen bills approved by the Society were signed into law. No bill disapproved by MSNJ became law. Here are the new laws to be noted and the Society's official position concerning them:

S-1 —To permit a dentist to receive payments for claims under a medical service plan for services performed in an approved hospital. (Chapter 1) *Approved*

S-74 —To permit boards of chosen freeholders to make appropriations for the benefit of mentally retarded or mentally ill persons. (Chapter 10) *Approved*

S-85 —To limit the time for bringing actions at law by parents or guardians in behalf of minors under the age of 21 derived by reason of an injury to such minor. (Chapter 214) *Approved*

S-90 —To prohibit any home providing sheltered care for adult persons to advertise as equipped to care for mentally ill or retarded persons; to prohibit operation as a hospital or nursing home. (Chapter 147) *Approved*

S-92 —To establish enforcement procedures in violations involving private mental hospitals, convalescent and private nursing homes, and private hospitals. (Chapter 148) *Approved*

S-93 —To provide for the issuance of group contracts by a hospital service corporation and combined contracts by a hospital service corporation and a medical service corporation; to provide for experience rating and a supervisory fee of 2 cents, to be paid to the Commissioner of Banking and Insurance. (Chapter 104) *Approved*

S-94 —To provide for the issuance of group contracts by a medical service corporation and combined contracts by a medical service corporation and a hospital service corporation; to provide for experience rating and a 2 cents supervisory fee, to be paid to the Commissioner of Banking and Insurance. (Chapter 105) *Approved*

S-171—To permit bio-analytical laboratory testing only by laboratories registered in New Jersey. (Chapter 234) *No Action*

S-181—To authorize charges for diagnostic services and treatment at county mental centers or institutions. (Chapter 189) *Approved*

S-182—To permit county hospitals to accept private patients who cannot obtain admission within a reasonable time to a voluntary hospital in a county. (Chapter 200) *No Action*

S-210—To establish a Narcotics Advisory Council, within the Department of Institutions and Agencies, to study, promote and effectuate a comprehensive plan for the prevention and control of drug addiction, diagnosis, treatment, and control of addicts; repeals P.L. 1953, C. 449, creating a permanent commission on narcotic control. (Chapter 226) *No Action*

S-249—To permit the licensing of professional nurses at age 18, instead of 20. (Chapter 197) *Approved*

S-265—To provide for forfeiture of a motor vehicle license by anyone convicted as a user of narcotic drugs. (Chapter 227) *No Action*

S-276—To clarify the right of counties, municipalities, school districts, and agencies thereof to provide group insurance and hospital and medical services for elected and appointed officials and retired employees. (Chapter 259) *Approved*

S-314—To extend the provisions of the State Employees' Health Benefits Act to teachers and other local employee groups, keeping both groups separate for experience rating purposes; to authorize the Health Benefits Commission to permit retired employees to continue major medical coverage as well as basic coverage upon payment of premiums not less than would

have been paid had employment continued. (Chapter 125) *Approved*

A-42 —To provide that any person who uses, or is under the influence of or who possesses, or has under his control, amphetamine, barbiturate, barbital, hypnotic or somnifacient drugs, tranquilizers, or any prescription legend drug, in any form, unless obtained from a physician or on a valid prescription, is a disorderly person. (Chapter 225) *No Action*

A-360—To revise the statutes pertaining to production, handling, and distribution of milk, cream, and milk products. (Chapter 62) *Approved*

A-514—To provide for the mandatory reporting by physicians and hospitals of physical abuses of children. (Chapter 30) *Approved*

A-520—To require the testing of newborn children for the purpose of early detection of phenylketonuria (PKU); appropriates $10,000 for initiating program; effective January 1, 1965. (Chapter 268) *Action Deferred . . .* pending study and recommendation by the Special Committee on Maternal and Infant Welfare.

A-559—To provide for the establishment and maintenance of narcotic treatment centers by counties or municipalities. (Chapter 254) *Approved*

A-642—To establish criteria governing the sale of frozen desserts, to provide for the licensing of operators of frozen dessert plants, and to provide for the enforcement and promulgation of rules and regulations by the Department of Health. (Chapter 120) *Approved*

A-710—To include "any other agency, public or private, authorized to perform protective services for children" among those with which the county prosecutor may file a complaint concerning physical abuses of children. (Chapter 271) *Approved*

A-755—To appropriate out of the general State Fund the sum of $200,000 or so much as necessary to defray the expenses of the Narcotic Drug Study Commission created by JR9 (1964). (Chapter 247) Introduced too late for council action.

A-769—To create the New Jersey Medical and Dental College Act of 1964, to authorize the acquisition of the Seton Hall College of Medicine and Dentistry; to establish in the Department of Education the New Jersey College of Medicine and Dentistry under the direction of a 7 member Board of Trustees until July 1, 1970 and thereafter to create a temporary commission known as the New Jersey Council on Medical and Dental Education with administration of the college centralized within the state university system; to appropriate $4,000,000 for acquisition and $300,000 for operating costs through June 30, 1965. (Chapter 231) Introduced too late for council action, but supported by Board of Trustees' statement.

A-770—To authorize the Board of Governors of Rutgers, the State University, to borrow or commit the New Jersey College of Medicine and Dentistry to the expenditure of money not exceeding $6,000,000 plus interest in addition to other available funds to construct capital facilities necessary to operate a two-year program of medical education commencing with a request for $1,000,000 in the budget for the fiscal year ending June 30, 1966. (Chapter 232) Introduced too late for council action.

A-773—To appropriate $50,000,000 to be derived from the sale of New Jersey Institutions Construction Bonds (1964) for construction, reconstruction, development, extension, improvement, fixed equipment of several state mental, charitable, hospital, relief, training, correctional, reformatory or penal institutions, all for health and welfare purposes. (Chapter 224) Introduced too late for council action.

Following is a list of bills from the 1964 session vetoed by the Governor and the Society's position concerning them. With the exception of S-235, which was vetoed conditionally, all were vetoed absolutely.

S-235—To provide that any person who hires any drug addicted child under 18 years of age to transport or sell drugs shall be guilty of a high misdemeanor. *Approved*

S-236—To provide a mandatory 20-year prison term for any person who manufactures or sells drugs for profit with intent to corrupt youth. *Approved*

S-237—To prohibit suspension of sentences or placing on probation persons found guilty of violating the law governing the manufacture, sale, or transportation of drugs concerning youth. *Approved*

A-162—To require every person engaged or employed to drive school buses to undergo periodic medical examination to determine his mental and physical condition to safely operate such vehicle. *Approved*

A-261—To require a prescription for a narcotic be on a special narcotic prescription form of a type and design established by the Department of Health; requires prescription to be retained in a separate file. *Disapproved . . .* because it is unnecessary and unrealistic, and places a burden on the general public to protect itself against forgers and counterfeiters.

A-644—To provide that any person who has served as a municipal sanitary inspector first class in New Jersey for 10 years and as executive officer of a municipal board of health for 10 years shall be entitled to a license as health officer without examination. *Disapproved . . .* because it is special legislation discriminating against the public interest in favor of an individual.

1965 STATE LEGISLATION

The 189th session (1965) of the State Legislature opened in the afternoon of January 11. Since that time the council has considered the bills listed below. It is obvious from this listing that the volume of bills considered by the council continues to increase each year. In all its deliberations, the council has had the benefit of the analyses and critical comments of the Legislative Analyst.

The Society's official position on all bills is regularly called to the attention of component societies, through the minutes of the meetings of the Board of Trustees; of legislators, cooperating agencies, county keymen, secretaries and executive secretaries; by means of official bulletins; and of the members, through the *Membership News Letter* and *The Journal.*

The Board of Trustees has adopted the positions indicated. All measures thus marked (*) are identical with bills of preceding years, and the official position of the Society concerning them remains the same. The regular range of official positions is as follows:

Active Support . . . all-out support for the measure;

Active Opposition . . . all-out opposition for the measure;

Approval . . . commended as satisfactory, but not actively supported;

Disapproval . . . rejected as unsatisfactory, but not actively opposed;

No Action . . . considered, but not regarded as significant or relevant to the proper interests of the Society.

(Positions of active opposition and disapproval are always accompanied by a statement of reasons.)

*S-42 —To provide that no chemical analysis or speci-
*A-321—men of a defendant's blood may be taken in drunken driving cases against the physical resistance of such defendant. *Approved*

*S-51 —To require seat safety belts on automobiles
*A-314—registered, sold, or operated in the State after July 1, 1965. *Approved*

*S-54 —To prohibit, as a disorderly person's offense, the smelling or inhaling, or sale for such use, of glues capable of releasing toxic vapors causing intoxication, inebriation, excitement, or stupefaction; exempts anesthesia for medical or dental purposes and model kits. *No Action* . . . MSNJ recognized the inherent danger in glue sniffing and approved the principle embodied in the bill. However, it is the Society's opinion that the danger cannot be curtailed by legislation, but that control should be exercised at local level.

S-61 —To increase the membership of the hospital licensing board to 6; to require the appointment of one member selected from among the official boards and administrators of the several non-profit homes for the aged. *Approved*

S-63 —To amend the law regulating the disposition by an individual of his human remains. *Approved*

S-72 —To prohibit the expenditure or allocation of public funds and the provisions of public facilities for the support of, or in aid of, activities or programs from the benefits of which anyone is excluded for reasons of race, creed, color, or national origin. *Approved*

S-83 —To increase State competitive scholarships from $400 to $500 per year; includes schools of professional nursing within the category of accredited colleges. *Approved*

S-86 —To permit the Department of Health, or any local board of health, to direct the destruction or removal of wild or passenger pigeons if it finds that the presence of such pigeons is hazardous to the health of any state inhabitant. *Approved*

*S-94 —To provide that any resulting disease of the
*S-95 —respiratory system of a member of a paid fire
*S-96 —or police department shall be deemed an occupational disease. *Disapproved* . . . because they involve diagnosis by legislative enactment rather than by medical investigation.

*S-98 —To broaden the protection afforded employers
*A-176—in second accident prior disability cases under the Workmen's Compensation Act. *Approved*

*S-106—To define packaged medicines which may be sold by general merchants. *Disapproved* . . . because MSNJ is of the opinion that Section 2 of the measure empowers the manufacturer to determine what is non-poisonous. This section declares: ". . . the term 'non-poisonous' shall mean and include those preparations which are not dangerous to health when used in the dosage, or with the frequency or duration prescribed, recommended, or suggested in the labeling thereof." The Society considers that it is unwise and undersirable and contrary to the public interest that the manufacturer be the sole arbiter of what is "non-poisonous." Moreover, MSNJ looks with disfavor on any legislation which would relax the salutary controls necessary for the protection of the public and which would tend to encourage self-medication on the part of the public.

*S-145—To include under the scope of laws dealing with the practice of optometry any who offer and market for sale at retail to the general public spectacles or eyeglasses containing other than plano lenses. *No Action*

S-150—To designate the "State Health Aid Act of 1965;" provides for a program of State aid to local health agencies to establish and maintain a program of recognized public health activities. *No Action*

(Amended — see page 290)

*S-169—To provide for adjustment of contract rates of hospital service group contracts under experience rating plans approved by the Commissioner of Banking and Insurance. *Approved*

*S-170—To provide for adjustment of contract rates of medical service group contracts under experience rating plans approved by the Commissioner of Banking and Insurance. *Approved*

*S-171—To exempt from taxation, air and water pollution control equipment facilities and devices certified by the State Commissioner of Health. *Approved*

S-179—To afford legal protection under the Medical Practice Act to medical technicians and x-ray technicians carrying out procedures at the specific direction of a licensed physician. *Active Support* (MSNJ sponsored)

A-2 —To amend the Unemployment Compensation Act to provide a scale of benefits equal to 2/3 of a claimant's average weekly wage; repeals

the "active search for work" provision; provides an alternate method of establishing eligibility; provides full coverage for employees where employers employ 1 or more, immediate coverage for employers who elect coverage pursuant to a collective bargaining agreement. *No Action*

*A-3 —To permit an injured employee to select the physician he wishes to treat him under the Workmen's Compensation Act. *Approved*

A-5 —To revise the Workmen's Compensation Law; to increase weekly and other compensation. *No Action*

*A-8 —To authorize the Commissioner of Banking and Insurance to disapprove and determine the rate of payment to a participating physician under a medical service corporation or medical service plan. *Active Opposition* . . . because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by MSP to participating physicians and would therefore constitute an unwarranted and unjustifiable denial of the fundamental right of the physician to set his own fee for professional services rendered, thus threatening the operation of the Plan, in disregard of the best interests of the approximately two million people of New Jersey who are its subscribers.

*A-33 —To establish presumptions in certain illnesses of firemen and policemen. *Disapproved* . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-39 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease, or tuberculosis shall be deemed to be an occupational disease. *Disapproved* . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

A-56 —To presume, as a condition for a license, implied consent of car drivers to the taking of samples for the purpose of making chemical tests to determine the amount of alcohol in the blood where there is "reasonable" cause to believe that the person to be tested is under the influence of alcohol; effective on the 91st day following enactment. *Approved*

*A-59 —To limit the subrogation rights of insurance companies, or medical or hospital service corporations, with respect to third party recoveries for hospital or medical services. *Disapproved* . . . because the Society is on record approving the opposite principle, as contained in S-4 of 1963.

A-78 —To amend the Workmen's Compensation law to provide that whenever hospital services are required to cure or relieve an injured workman, he shall be entitled to hospital service of a quality and character no less than provided for patients receiving services known as "semi-private" room care. *Disapproved* . . . because it is based on the unsound premise that the quality of medical and nursing care in hospitals is controlled by the expensiveness of the accommodations.

*A-127—To make technical amendments in various statutes dealing with mental incompetents and their guardians. *Approved*

*A-128—To propose a general revision of the laws governing mental health, designated as "The Mental Health Act of 1965;" effective January 1, 1966. *Approved*

*A-129—To amend the law governing persons confined to institutions by court order, and to require persons admitted to the state sanatorium for convalescence from tuberculosis or respiratory disease be liable for care costs in the same manner and extent as required from mentally ill or retarded persons or relatives; effective January 1, 1966. *Approved*

*A-138—To revise the statutes concerning the practice of pharmacy and the regulation and control of the sale and distribution of drugs, medicines, and poisons. *Approved*

*A-169—To create a Division of Refuse Control in the Department of Health to regulate and license the collection and disposal of solid waste. *Disapproved* . . . in support of the position of the Health Department that the legislation is unnecessary and undesirable.

*A-176—To broaden the protection afforded employers
*S-98 —in second accident prior disability cases under the Workmen's Compensation Act. *Approved*

*A-180—To provide for the registration and examination of dental laboratory operators and their assistants by the State Board of Registration and Examination in Dentistry. *Disapproved* . . . in support of the position of the New Jersey State Dental Society, which contends that the bill is loosely drawn.

*A-204—To extend the time for filing petitions under the Workmen's Compensation Act in cases of exposure to ionizing radiation. *Approved*

A-248—To prohibit as a misdemeanor the selling of any glue, liquid cement or other similar substance which does not contain an irritant or nauseant; effective January 1, 1966. *Disapproved* . . . because it would pose an unjustifiable hazard for all those who must use such materials regularly.

*A-271—To amend the Absentee Voting Law to eliminate the need for a physician's certificate in connection with an absentee ballot for temporary disability. *Disapproved* . . . because it would encourage self-diagnosis.

A-280—To prescribe new penalties for operating a motor vehicle while the ability to operate such motor vehicle is impaired by the consumption of alcohol, provides that the presence of 0.10% or more weight of alcohol in the defendant's blood would create a presumption of impairment. *Approved* . . . with reference to the standards of percentile ratio of alcohol by weight to establish the presumption of impairment, but without commitment as to the fairness of the penalties declared.

*A-314—To require seat safety belts on automobiles
*S-51 —registered, sold, or operated in the State after July 1, 1965. *Approved*

*A-321—To provide that no chemical analysis or speci-
*S-42 —men of a defendant's blood may be taken in drunken driving cases against the physical resistance of such defendant. *Approved*

A-325—To prohibit as a disorderly person one who wrongfully obtains, or attempts to obtain or procure, the administration of amphetamine,

barbiturate, barbital, hypnotic or somnifacient drugs, tranquilizers, or any prescription legend drug. *Disapproved* . . . because, in view of the enactment of A-42 of 1964 (Chapter 225), this legislation seems unnecessary and redundant.

A-338—To provide that the State Department of Health, its officers, agents, inspectors, and representatives, and all peace officers and county prosecutors shall enforce all provisions of law concerning amphetamine, barbiturate, barbital, hypnotic or somnifacent drugs, tranquilizers, or any prescription legend drug. *Disapproved* . . . because, although the purpose of the bill is good, MSNJ is of the opinion that the responsibility involved should rest with the Board of Pharmacy in the Division of Professional Boards.

A-365—To require every person selling any article of food which has been frozen and permitted to thaw to label the package or container stating: "This article of food was frozen and permitted to thaw." *Approved*

*A-370—To prohibit the discharge of pollutant matter or materials into inland tidal waters and to regulate the operation of toilet facilities in vessels in said waters. *Approved*

*A-379—To provide that any person who shall hypnotize, or attempt to hypnotize, another person for purposes of entertainment is a disorderly person. *Approved*

*A-421—To require a copy of the results of a breath and chemical test be given to a person accused of drunken driving; to permit the person tested to have the tests made by a person of his own selection; presumes that the refusal of a person to take a test would have an illegal percentage, by weight of alcohol, in the blood. *Approved*

*A-434—To provide that eligible persons may continue to receive assistance for the blind while in certain medical institutions. *Approved*

A-467—To provide for the preparation of students for general practice in the professions of medicine and dentistry. *Approved*

*A-481—To amend the act regulating nursing; reduces the age for professional nurse candidates from 20 years to 18 years; raises fees for examinations and registration. *Approved*

*A-489—To transfer certain approval powers over hospital service corporations from the Commissioner of Institutions and Agencies to the Commissioner of Banking and Insurance. *No Action*

*A-491—To provide that a licensed sanitary inspector first class who has served as a municipal health department executive officer for one or more years shall be qualified to take the examination for a health officer's license. *Disapproved* . . . because it is special legislation, discriminating against the public interest in favor of an individual.

A-499—To regulate the practice or profession of removing superfluous hair from the body through registration and licensing of electrologists by the Board of Medical Examiners. *Approved*

A-502—To provide that a drug addict who uses any child under 18 years of age to carry or sell drugs is guilty of a high misdemeanor. *No Action*

A-508—To require every board of education to employ a school nurse. *Disapproved* . . . because it is mandatory not permissive; because such services are already provided under existing law by qualified nursing personnel; and because of the present limited supply of professional nurses in New Jersey.

MEDICAL TECHNICIANS

The council's number one project continues to be an amendment to the Medical Practice Act to afford legal protection to medical and x-ray technicians. Early in the 1965 legislative year, it sought the asistance of Senator Wayne Dumont (Warren County). On February 17, with Senator Frank Farley (Atlantic County) as co-sponsor, Senator Dumont introduced the Society's bill (S-179). The council is hopeful that it has evolved an appropriate amendment which will overcome the objections raised last year by the Governor's counsel. In its message to the Legislature urging the passage of this legislation in the interest of patient care, the council said:

"Medical and x-ray technicians are indispensable in assisting physicians and surgeons in administering certain approved and frequent procedures employed in the proper diagnosis and treatment of patients. This amendment, therefore, is necessary and desirable to insure the availability of such services to patients by adjusting the Medical Practice Act to the expanding modalities of modern medical care. Adoption of S-179 will bring the Medical Practice Act up to date.

"In addition to having the support of The Medical Society of New Jersey, S-179 likewise has the approval and support of the State Board of Medical Examiners, the State Department of Health, the State Board of Control, the New Jersey Hospital Association, the Radiological Society of New Jersey, and the New Jersey Society of Pathologists.

"The enactment of S-179 into law is imperative for the continued provision of these important services under circumstances insuring

maximum advantage and protection to the public."

CONFIDENTIAL MEDICAL STUDIES

The council reviewed Resolution #10 (from Middlesex County) adopted by the 1964 House, urging the passage of a bill to provide "medical studies conducted by the New Jersey Department of Public Health, MSNJ, allied health societies, and in-hospital staff committees of accredited hospitals will be of confidential character and shall be used only for medical research."

This resolution referred to a proposed bill submitted by the New Jersey Hospital Association for appreciation and criticism of MSNJ. It was referred to the Legislative Analyst, who supplied a detailed study and analysis—which was shared with the New Jersey Hospital Association.

The council agreed that, since no specific legislation has yet been introduced, MSNJ could not take an official position.

MENTAL HEALTH LAWS

The recommendation from the 1964 annual report of the Committee on Mental Health adopted by the House urging active support by MSNJ of legislation to modernize existing mental health laws was referred to the council. In consistently recommending a position of "approval" of bills introduced in the legislature to achieve this end, the council has complied with the recommendation of the committee.

DRUG ADDICTION

The Board referred to the council that portion of Resolution #1 (Middlesex County) adopted by the 1964 House calling upon the Society to "encourage the State Legislature in demanding more stringent laws concerning the imprisonment of people involved in the illegal sale of narcotics and drugs." It was the opinion of the council that, by taking an official position of approval on several bills introduced in the 1964 and 1965 sessions from the New Jersey Narcotic Control Commission to accomplish this objective, the council has achieved the purpose of this section of the resolution.

PRE-EMPLOYMENT PHYSICAL EXAMINATIONS

Referred to the council was Resolution #2 (Sussex County), adopted by the 1964 House, urging MSNJ to develop and support the passage of amendments to existing law requiring that pre-employment physical examinations (on persons under 18) should be performed by either freely chosen or designated physicians. The council submitted to the Board of Trustees, which approved it, the following draft of proposed legislation:

AN ACT to amend "An Act to limit and regulate child labor in this State; to provide for examinations and inspections under the provisions of this act; to provide for the enforcement of this act and regulations made thereunder; to prescribe penalties for the violation thereof; and to repeal other acts," approved June 25, 1940 (P.L. 1940, c. 153).

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. Section 8 of the act of which this act is amendatory is amended to read as follows:

8. The issuing officer shall issue such certificates only upon the application in person of the minor desiring employment, and after having approved and filed the following papers:

. . . (3) A statement of physical fitness, signed by a medical inspector employed by the applicable board of education, *or any other physician licensed to practice medicine and surgery,* setting forth that such minor has been thoroughly examined by such medical inspector, *or such other physician licensed to practice medicine and surgery,* that he either is physically fit for employment in occupations permitted for persons under eighteen years of age, or is physically fit to be employed under certain limitations, specified in the statement. If the statement of physical fitness is limited, the employment certificate issued thereon shall state clearly the limitations upon its use, and shall be valid only when used under the limitations so stated. The method of making such examinations shall be prescribed jointly by the Commissioner of Education and the State Department of Health.

In line with the Society's policy decision not to introduce legislation until such time as positive action is taken on the medical technicians' bill, this bill will be introduced at the earliest practicable time.

AREAWIDE PLANNING FOR HOSPITALS

Referred to the council was Resolution #7 (Essex County), adopted by the 1964 House, urging MSNJ "to express its opposition to any attempt to pass enabling legislation making recommendations of planning councils compulsory at either the state or regional level." The council received this resolution for subsequent implementation, if and when such legislation is introduced.

STATEWIDE MEDICAL EXAMINERS' SYSTEM

In furtherance of its efforts to attain the purposes set forth in Resolution #1, adopted by the 1963 House of Delegates, on September 16, 1964, the council sponsored a meeting of representatives of component societies, to discuss possible improvement of the present system of investigating unusual deaths in New Jersey and to arrive at a means whereby such improvement could best be brought about under a statewide medical examiners' system. As the result of this meeting, a communication was sent to the Governor, urging his cooperation and assistance in the establishment through the Legislature of a state wide medical examiners' system. Subsequently, additional data—including an outline proposal for such a system—were supplied in response to an official request. The matter is currently being reviewed by the Governor's personal counsel.

LICENSURE OF ELECTROLOGISTS

Representatives of the council met during the year with conference groups to evolve acceptable legislation which would, in protection of the public interest, enable qualified electrologists to conform to certain standards under licensure and to place the practice of electrolysis directly under the control of the State Board of Medical Examiners. In arriving at its decision to recommend that the Board approve licensure for electrolysis, the council concluded that members of this group are not paramedical personnel, since their type of service is not rendered at the specific direction of licensed physicians and since it is more closely related to the practice of beauticianry than to the practice of medicine. Supervision by the State Board of Medical Examiners will insure non-invasion of the Medical Practice Act. A bill (A-499) has been introduced in the 1965 session which embodies the suggestions of MSNJ, and concurred in by the New Jersey Dermatological Society. It is reported under "current state legislation."

COUNTY AND FEDERAL KEYMEN

The council continues to ultilize its county and federal legislative keymen as the means of making clear to legislators the official positions of the Society. Upon their shoulders, therefore, rests the responsibility for the effectiveness of the Society's services to state and federal legislators. Informational bulletins are routinely supplied. Special bulletins, prepared by the Executive Director, inform the keymen when action is necessary concerning particular measures, so that the legislators can be approached in their own counties and congressional districts, and their support of the Society's position(s) sought with substantiating reasons given.

COUNTY ACTION ON STATE LEGISLATION

In the interest of unity and efficiency of action on the part of organized medicine, the council reaffirms its recommendation to county societies that they not commit themselves concerning pending legislation until they have first cleared with MSNJ, to ascertain the official position adopted by the Society. The Council on Legislation—with the aid of its Legislative Analyst, who is a lawyer expert in the language of legislation—studies painstakingly all state legislation of medical interest. Then, with full appreciation of all that is involved, it submits recommendations concerning official positions to the Board—or the House of Delegates, when it is in session—and the official positions are by these bodies determined.

OPERATION ELDERCARE

A special session of the AMA House of Delegates was held in Chicago on February 7 and 8 to review current proposed national health legislation, to determine the position of or-

ganized medicine with reference to that legislation, and to agree upon the educational program that would be waged on a national scale to achieve the defeat of unsatisfactory measures and the adoption of satisfactory ones.

The AMA House gave unanimous support to the Herlong-Curtis Eldercare Bill (H.R. 3727) as embodying the basic principles of the AMA program. This bill—known as the "Eldercare Act of 1965"—would amend the Social Security Act to add a new section under which a state with an MAA program would be authorized, in its discretion, to provide medical assistance to the aged in the form of premium payments for health insurance coverage under voluntary private health insurance plans. The Society's part in this national program in support of the AMA's campaign was arrived at by the special ad hoc committee appointed by the Board of Trustees for just this purpose. It is reviewed in detail in the annual report of the Board of Trustees.

Because the State Legislature continues to meet in regular session, the council will meet in mid-April. Thus, a supplemental report will be submitted to the House of Delegates, to bring the membership up to date on current state legislation.

Approved (page 351)

Supplemental Report

Since preparation of the annual report of the Council on Legislation, distributed in advance to the House of Delegates, it has been necessary for the council to hold another meeting in order to supply recommendations concerning state legislation recently introduced.

To bring the House up to date concerning the legislation thus dealt with and concerning the Society's positions as approved by the Board of Trustees, the council respectfully presents this supplemental report.

S-69 —To require all motor vehicles—other than A-137—diesel-powered—motorcycles, and electric vehicles to be equipped with crankcase ventilating systems of a type approved by the Air Pollution Control Commission. *Disapproved* . . . because there is no provision for inspection or enforcement of the law by means of a supervisory or responsive body.

S-143—To establish a State Public Sanitary Sewerage Facilities Assistance Act of 1965. *Approved*

S-150—To designate the "State Health Aid Act of 1965"; provides for a program of state aid to local health agencies to establish and maintain a program of recognized public health activities. *Approved*

This bill, which was originally voted a position of "no action", was reconsidered by the Board of Trustees at the recommendation of the council and was given a final position of "approval".

S-195—To forbid the suspension of any sentences for the illegal manufacture or sale of narcotic drugs. *Approved*

S-196—To provide a prison term of not less than 20 years for hiring or use of any child under 18 years of age in illegal sales or transactions of certain narcotic drugs. *Approved*

S-197—To increase the penalties of certain narcotics violations and to forbid suspension of sentences. *Approved*

S-218—To permit appointment of any physician licensed and employed as a health officer by a municipality to a board of managers of county hospitals, notwithstanding he is not a citizen of the county. *No Action*

S-227—To require pupils and teachers to use eye protective devices while attending classes in vocation or industrial art shops or laboratories where processes are taught which may cause damage to the eyes. *Approved.*

S-230—To provide that no motor vehicle shall be A-587—registered unless it complies with standards for controlling emission of contaminants established by the Air Pollution Control Commission. *Approved*

S-231—To provide that the Air Pollution Control A-585—Commission shall formulate rules establishing standards of allowable emission of contaminants from motor vehicles, standards of quality of fuels, and standards for types of air pollution control devices to prevent air pollution. *Approved*

S-266—To prohibit discrimination in issuance, extension, or renewal of any policy of automobile insurance because of race, creed, color, national origin, or ancestry, or age. *No Action*

A-177—To permit the parole of persons convicted of specified sex crimes by a special 5-member parole board appointed by the Governor, with Senate advice and consent, and with concurrence of the sentencing judge. *Disapproved* . . . because the bill does not specify the qualifications of the members of the special parole board.

A-388—To define as an unfair and deceptive practice the making of any health or accident insurance contract which excludes payments in part or in whole under another such contract without providing for a reduction in premium payments. *No Action*

*A-480—To provide for the care, treatment, and rehabilitation of the mentally ill. *Approved*

A-513—To permit suspension or denial of a pharmacist's license to anyone convicted of violating any state or federal law relating to dispensing of drugs; to prescribe acts considered grossly unprofessional and to prescribe operating criteria before a permit will be issued. *Approved*

A-514—To create "The Motor Vehicle Pollution Control Act" (1965) to control the emission of

pollutants from motor vehicles; to establish a Motor Vehicle Pollution Control Board in the Department of Health and to provide for administration. *Disapproved* . . . as unnecessary, because it is a duplication of facilities provided for in S-230, which MSNJ approved.

A-520—To exempt from examination those resident physicians of a resident medical staff who have not served as such for 5 years and within the discretion of the Board of Medical Examiners those physicians employed in a state or county institution on a salary basis on its medical staff or as a member of the teaching or scientific staff of a state agency provided they continue in such positions and do not conduct a private medical practice. *Action Deferred* . . . pending correction of the legislation.

A-529—To require licensing and regulation of convalescent homes, private nursing homes and hospitals, and to create a hospital licensing board. *No Action*

A-559—To create an 8-member commission—4 appointed by the Governor and 2 each by the president of the Senate and the Speaker of the General Assembly—to study the advisability of state aid to public and non-profit hospitals for the care of indigent patients. *No Action*

A-603—To provide for licensing of persons engaged in the practice of podiatry. *No Action*

A-609—To require pupils and teachers to use eye protective devices while attending vocational or industrial art shops or laboratories where processes are taught which may cause damage to the eyes. *No Action* . . . in view of the Society's approval of S-227.

*A-612—To require the use of humane methods in the slaughter of livestock. *No Action*

A-627—To change the filing date of the report of taxable personal property with an assessor from May 1 to July 1; to authorize an assessor to establish values of such property where a return has not been filed and to establish penalties for false returns or failure to file returns within the prescribed time. *No Action*

*A-636—To revise the statute creating the Division of the Aging with respect to the office of Director and the Commission on Aging. *No Action*

A-657—To grant married minors and unmarried pregnant women who are minors the legal right to consent to the performance of hospital, medical, or surgical care on themselves and their infants. *Active Support*

A-658—To permit hospitals to destroy unneeded records after a 7-year period and to destroy x-ray film after 5 years. *No Action*

A-659—To permit municipalities to lease municipal property to non-profit general hospitals, except that this shall not include real estate owned by a board of education. *No Action*

A-661—To establish a "Worker Health and Safety Act." *No Action*

A-665—To require every motor vehicle manufactured after July 1, 1967 to be equipped with a signalling system. *Approved*

A-674—To create a 9-member Automobile, Highway, and Traffic Safety Study Commission to study automobile safety devices including safety belts, headlights, steering equipment, and other safety devices, highways, and traffic regulations. *Approved* . . . subject to the appointment of a doctor of medicine as a member of the commission.

A-715—To include a school of professional nursing of collegiate grade accredited and approved by the State Board of Education under the Higher Education Assistance Authority Act. *Approved*

Approved (page 351)

Medical Services

Irving Klompus, M.D., Chairman, Bound Brook

(Reference Committee "F")

The Guides for Physician-Hospital Relationships in New Jersey have been circulated. Concurrence from the New Jersey Hospital Association has been received only for Section VI which concerns contributions by doctors to hospitals. More meetings with the NJHA are being sought to implement more of the principles of the Guides.

The council was requested to investigate and study the fee schedule of the New Jersey Rehabilitation Commission. Meetings with the Commission representatives are underway in an effort to develop a more realistic fee schedule.

The council investigated a complaint that relatively few anesthesiologists participate in Blue Shield; thus patients do not usually have free choice of anesthesiologist. The investigation showed that only 53% of anesthesiologists participate in Blue Shield, but more important

the distribution of patients is not uniform—many large areas have no participating anesthesiologists and some of the small areas have 100% participation.

The council feels that non-participating anesthesiologists (as well as all other non-participating physicians) should be urged to reconsider and become participating physicians in the Blue Shield Plan. The council also feels that an upward adjustment of fees for anesthesiologists is not the solution inasmuch as an upward adjustment for them would also mean an upward adjustment of other fees which could only result in increased rates. It is the consensus of the council that there is no solution to the problem at this time, and it so reported to the Board of Trustees.

Accepted as progress report (page 352).

Suggested that further study be given to the Medical-Surgical-Anesthesiology problem toward some satisfactory solution of this difficulty.

Special Committees to the Council on Medical Services

Occupational Health

Delma W. Caldwell, M.D., Chairman, Linden

and

Workmen's Compensation

Joseph A. Lepree, M.D., Chairman, Elizabeth

(Reference Committee "F")

Inasmuch as the activities of the two committees this year were for the most part joint endeavors and they met in joint session, this combined report is presented.

In joint session, the committees discussed the procedures to be followed in connection with the revision of the Workmen's Compensation Law in New Jersey. It was recommended last year—and approved by the House—that further action be taken with the State Department of Labor and Industry with regard to the determination of disability from the viewpoint of physical impairment to be evaluated by physicians and permanent disability to be evaluated by an impartial group (as recommended by the AMA and adopted by MSNJ). A conference with representatives of the State Department of Labor and the Division of Workmen's Compensation was arranged. Representatives from the two committees and the Board of Trustees constituted a special committee of MSNJ for this purpose. There was no definite action on anything at the conference, and a subsequent meeting is planned. In the meantime, the committees are studying an "Analysis and Critique of S-282." This 1964 legislation would amend the Workmen's Compensation Law broadly, including provision for maintenance by employers of a panel of physicians to treat injured employees. It was disapproved by MSNJ in consistency with the declared position of MSNJ in support of free choice of physician.

The chairman of the Committee on Occupational Health, as the official representative of MSNJ, attended and reported upon the 24th Annual Congress on Occupational Health, sponsored by the AMA Council on Occupational Health, last September in Houston, Texas.

Next year, the Committees on Occupational Health, Rehabilitation, and Workmen's Compensation will be merged into one committee in view of their mutual problems, missions, and activities. This merger has the endorsement of the committees which it involves.

Accepted as progress report (page 353)

Public Health

John B. Fuhrmann, M.D., Chairman, Flemington

(Reference Committee "G")

DRUG ADDICTION PROBLEMS

The 1964 House approved a resolution on "Drug Addiction Problems." The second section of this resolution was referred to the Council on Public Health. This section reads: "That the Medical Society representatives meet with the Narcotics Advisory Committee to formulate proper procedures for the treatment and follow-up care of addicts."

In order to implement this, a subcommittee of the Council on Public Health was appointed, consisting of Peter J. Guthorn, M.D., chairman (member of the Council on Public Health); David R. Lyons, M.D. (member of Special Committee on Child Health); and Edward A. Schauer, M.D. (member of the Special Committee on Mental Health).

The Council on Public Relations has attempted to implement paragraph one of the resolution; the Council on Legislation has started action on paragraph three of the resolution; and the subcommittee of the Council on Public Health stands ready to meet with the proper authorities to implement their portion of the resolution when the opportunity presents.

Approved (page 354)

SABIN ORAL POLIO VACCINE IMMUNIZATION

During late 1963 and early 1964, each county in New Jersey conducted a countywide drive to immunize the population with Oral Sabin Polio Vaccine. The number of doctors, nurses, pharmacists, and volunteers together with members of the Department of Health of the State of New Jersey that took part in making this drive a success totaled in the thousands. To each individual that took part, we of the Council on Public Health give a sincere vote of thanks. The overall state figures that we have been able to collect show that far better than 50% of New Jersey's residents are now immunized with Oral Sabin Polio Vaccine. As the physicians in the State of New Jersey continue to use this vaccine in their offices, this percentage of the population so vaccinated will continue to grow, so that before long Polio will become a thing of the past in New Jersey.

AIR POLLUTION

Last year a Subcommitte on Air Pollution was appointed to the Council on Public Health, with Dr. Roslyn Barbash designated as chairman. The subcommittee has had at least six meetings during the past year. Its members have contributed greatly to the volume of information being collected for the control of air pollution in New Jersey. They have worked long and diligently to assist current legislative committees in formulating the bills that are now pending before the legislature and in encouraging the preparation of additional and more far-reaching legislation that will be forthcoming in the future. This subcommittee, and especially its chairman, demands a special vote of thanks from the Council on Public Health for its excellent work this year.

Approved (page 354)

RECOMMENDATION

That the Board of Trustees of The Medical Society of New Jersey make the Subcommittee on Air Pollution a special committee under the Council on Public Health.

Approved (page 354)

SPECIAL COMMITTEES

This year the work of the Council on Public Health has been streamlined by the fact that the special committees have had their meetings prior to council meetings and their minutes have been available for council deliberation. Of the eight special committees reporting to

the council, three had three meetings; three had two meetings; and two had but one meeting. This gives some credence to the recommendation made last year that the special committee structure of The Medical Society of New Jersey undergo revision. Some progress has been made toward this end during the last year.

Several of the special committees deserve special credit and mention for outstanding jobs during the past year:

1. *The Committee on the Chronically Ill and the Aging,* under the able chairmanship of Matthew E. Boylan, M.D., made an outstanding contribution toward improving operations under the Kerr-Mills Law in New Jersey. Dr. Boylan was an official representative of MSNJ at a special AMA Conference on the Kerr-Mills Law, held in Chicago on January 9-10. From that Conference, Dr. Boylan brought back to the Board of Trustees a detailed report which was instrumental in influencing the Society's official recommendations for the improvement of New Jersey's Medical Aid to the Aged Program. (See report of the Special Committee on the Chronically Ill and the Aging.)

Approved (page 354)

2. *The Committee on the Conservation of Vision* conducted its 8th Annual Eye Health Screening Program last September. This was by far the best and most comprehensive program to date. The number of participating centers was increased by 5.9% over 1963; the number of persons screened was increased by 58%; the number of positive results was increased by 61.5%; and the number of negative results was increased by 54%. Again, this shows tremendous cooperation by the ophthalmologists in the state. We wish to salute Dr. Siegel, chairman of this committee, and his committee members for a job well done.

Approved (page 354)

3. *The Committee on Mental Health,* under the chairmanship of Robert Garber, M.D., again tackled the difficult problem of privileged communication for physicians. This is a continuous problem which seems very difficult to solve without the cooperation of the Bar Association and the Judiciary. Progress is being made in this field, and again our commendation to this committee for their work. (See report of the Special Committee on Mental Health.)

Approved (page 354)

MISCELLANEOUS

Each year of my association with the Council on Public Health gives me renewed admiration for the officials in the Department of Health of the State of New Jersey. Again this year, the cooperation we have received from the Commissioner of Health, Roscoe P. Kandle, M.D., and his staff has been outstanding. The amount of material and statistics that they have at their finger tips to augment our deliberations is fantastic. My personal thanks, and the thanks of each member of the council, to Dr. Kandle and his staff for their continued advice and support.

Lastly, my personal thanks to each of the chairmen of the special committees and to the members of the council for their cooperation during the last year. I trust that the same will continue during the coming Medical Society year, and that we may build well on the foundations that have been so soundly started.

Suggestion of House re Resolutions

That component societies and their members who have resolutions to propose to the House of Delegates refrain from releasing reports on their resolutions to the press before the House has had an opportunity to consider and act upon such resolutions.

Adopted

Air Pollution

Roslyn Barbash, M.D., Chairman, Teaneck

(Reference Committee "G")

Established this year, the Subcommittee on Air Pollution to the Council on Public Health has been very active.

OBJECTIVES

1. To increase physician awareness of the effect of air pollution on health;

2. To orient the physician as to air pollution control by better understanding of (a) meteorology; (b) pollutants, as to type, source, dissemination, and levels; (c) controls, both technological and legislative, existing and pending; and (d) enforcement; and

3. To support the State Health Department, as requested.

ACCOMPLISHMENTS

Objectives 1 and 2 were achieved by:

1. Cooperation with the New Jersey State Department of Health in the planning of a Physicians' Conference on Air Pollution, which was held on January 20, 1965 in Newark, to which all members of MSNJ were invited.

2. Dispatch of letters to the 21 component societies suggesting that an Air Pollution Committee be established in each county. To date, 15 counties have carried out this suggestion: Atlantic, Bergen, Burlington, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Middlesex, Monmouth, Ocean, Passaic, Somerset, and Union.

Amended to add Mercer, Morris, and Camden Counties to the roster of counties having established air pollution committees.

3. Dispatch of literature pertinent to the subject of air pollution to the county committees: Report of Motor Vehicle Committee to the New Jersey Air Pollution Control Commission, Report of the U.S. Senate Subcommittee on Air Pollution, and other material.

Objective 3 was implemented by study of the Motor Vehicle Report to the New Jersey Air Pollution Control Commission and study of the three motor vehicle pollution control bills approved by the Commission and additional proposed legislation.

The Council on Public Health has approved the committee's recommendations for program activity next year.

Approved as amended **(page 354)**

Cancer Control

John L. Olpp, M.D., Chairman, Englewood

(Reference Committee "G")

A survey of 99 general hospitals licensed by the State of New Jersey and 25 government hospitals yielded the following information:

For 97 General Hospitals:

54 have committee on cancer *and* a tumor registry
30 have *no* committee on cancer or tumor registry
6 have *only* a committee on cancer
7 have *only* a tumor registry

For 19 Federal, State, County and Municipal Hospitals:

7 have committee on cancer *and* a tumor registry
2 have *only* a tumor registry
10 have *no* committee on cancer or tumor registry

An article sponsored by the Committee on Cancer Control and written by Sylvan E. Moolten, M.D., New Brunswick, entitled "Is Cancer A Preventable Disease?" has been approved by the Council on Public Health and Board of Trustees for publication in *The Journal.**

Wider use of the "Pap" test should result if members of The Medical Society of New Jersey accept and encourage the professional and public educational programs sponsored by the New Jersey Division of the American Cancer Society.

The committee urges that all physicians have a thorough annual physical examination and encourage their patients to have periodic health maintenance examinations.

Approved (page 354)

Child Health

Robert E. Jennings, M.D., Chairman, South Orange

(Reference Committee "G")

The Committee on Child Health respectfully submits the following report of its activities for the year 1964-65.

Two meetings of the Special Committee on Child Health were held during the year, 1964-65.

Through the cooperation of MSNJ with the Battered Child Subcommittee of the Youth Commission, New Jersey Department of State, effective protective legislation was passed requiring physicians of New Jersey to report cases of suspected child abuse.

The chairman, as liaison member, represented MSNJ at one meeting of the Advisory Council of the New Jersey State Department of Education, Division of Curriculum and Instruction. The meeting was concerned with proposed extensive changes in legislation for the education of the handicapped. No commitments were indicated.

The main efforts of the committee were di-

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rected at Child Safety. Mindful of the poor results of our efforts of last year, largely due to poor motivation at the county and local community level, certain changes were proposed. The Board of Trustees of The Medical Society of New Jersey concurred in these: namely,

1. Closer liaison with the New Jersey State Safety Council—such liaison exists, but needs to be initiated by the Child Health Committee.

2. Liaison should be established with the New Jersey Congress of Parents and Teachers. The Board of Trustees sanctioned this liaison, and Dr. Bedrick was appointed as official liaison officer.

3. Annual reports from the child health committees of the component medical societies should be sent to the Child Health Committee of MSNJ, to evaluate activity and progress in the child health program.

To further the activities on child safety, new materials were found. Two comprehensive books on this vital subject have become available to the county chairmen. These are: *"Action Programs for Accident Prevention in Tennessee,"* by the Tennessee Department of Health; and *"Suggestions to Aid in Conducting a Child Safety Week,"* provided by the Prudential Insurance Company of Newark, New Jersey.

Closer liaison is anticipated between MSNJ and the Accident Prevention Coordinator, New Jersey State Department of Health. Mr. Henry Young of this Department met with the committee and was most helpful. It is hoped that much of the educational material for the work on accident prevention may ultimately be available through this agency, cooperating with MSNJ.

To enable the communities to utilize these facilities, MSNJ requested Governor Hughes to proclaim the week of April 5-12, 1965 as *Child Safety Week*. Proper newspaper coverage of the proclamation has been arranged with the cooperation of the Council on Public Relations.

Dr. William Farley of Nutley, a member of this committee, will present an exhibit on childhood accidents at the 199th Annual Meeting of MSNJ. Dr. Farley is also completing a booklet on *"The Seriously Injured Child."* Material for this was presented at the convention of MSNJ in 1963.

The New Jersey Association for School Physicians was formally organized in May 1964, through the efforts of the Child Health Committee. Dr. David Lyons of East Orange is President. Cooperation for changes in the mandatory law on school health examinations from this group is anticipated. Such changes were approved by the 1963 House of Delegates of MSNJ. A meeting of the newly formed Association with school personnel is planned for May 1965.

Cooperation will be invited from the Comissioner of the New Jersey State Department of Education on the proper use of eye goggles in hazardous school situations as well as on the proper utilization of ophthalmologists in the teaching programs of the State Teacher Colleges.

The chairman wishes to express his appreciation of the hearty cooperation of the committee and the sincere guidance and assistance of the secretarial staff of the executive offices.

Approved (page 354)

Chronically Ill and The Aging

Matthew E. Boylan, M.D., Chairman, Jersey City

(Reference Committee "G")

The year 1964-65 was perhaps the busiest and most productive year for the committee in the last several years. Numerous new questions and problems arose, were discussed, and recommendations were submitted to the Council on Public Health and directly to the Board of Trustees as the situation warranted.

The committee held three regular meetings, one special meeting, and the chairman attended a National Conference on Kerr-Mills, sponsored by the AMA. The report of the conference was submitted in detail to the Board of Trustees.

The accreditation of nursing homes was discussed in length. The advisability of rendering approval and support was considered. It was the recommendation of the committee that the situation be kept under surveillance. The committee expressed full confidence in the Department of Institutions and Agencies and those members of the Society who are in the advisory capacity to the Department. The committee will continue to evaluate the problem; and if at any time it has further recommendations, they will then be made.

Because of the chronic nature of emphysema and its complications, and because of the increase in the incidence and diagnosis of emphysema as an entity, it was recommended that: "In addition to cancer and tuberculosis, we should begin taking a more astute view of the terrific increase in cases of emphysema that we see in our hospitals today; and that any and all suggestions made toward reducing emphysema—such as by reduction of fumes, noxious gases, smoking, etc.—be re-evaluated and controlled, if possible." Our recommendation was referred to the Subcommittee on Air Pollution.

Due to the increasing number of Cardiac Surgical Centers within the State—with not infrequent duplication of facilities within limited geographic areas—the committee, after full discussion of the situation recommended: "That the Board of Trustees urge the Society's representatives on the New Jersey Health Facilities Planning Council to encourage centralization and more effective cooperative utilization of cardiovascular surgical centers throughout the State."

In the discussion of the Medical Assistance to the Aged Program in New Jersey, it was demonstrated that the implementing legislation called for a Medical Advisory Committee. The committee recommended that the Board of Trustees urge the Department of Institutions and Agencies without further delay to appoint a Medical Advisory Committee to the Division of Public Welfare to lend assistance in the medical programs supervised by that Division; and urged that in furtherance of this objective, the Society submit a list of nominations for appointment.

In compliance with the above recommendation, the Board has submitted a list of five (5) nominees and five (5) alternates to the Commissioner of the State Department of Institutions and Agencies.

The committee gave attention to the fact that, in consequence of the current National Educational Program under the sponsorship of the AMA, it is necessary and desirable that the Society have a full and accurate understanding of the MAA Program in New Jersey, functioning in implementation of the Kerr-Mills Law. To that end, the committee was of the opinion that it is important that a thorough study be made available to our members, so that the Society may move to amend and improve the New Jersey MAA Program, if it finds it necessary to do so.

Because of its concern with the chronically ill and the aging, the members felt that this committee would be a proper committee to engage

in this study. Therefore, the committee recommended that it be assigned the responsibility for studying approaches and making recommendations toward the improvement of the MAA Program in New Jersey. This recommendation was approved by the Board of Trustees in October 1964.

The committee then concentrated its efforts to this end, and as a result of its study produced a series of recommendations calculated to increase the efficacy, efficiency, and acceptability of New Jersey's MAA Program.

It was the feeling of the committee that the "responsible relatives provision" is the most distasteful provision in this bill, insofar as the recipients are concerned. Few people object to a spouse or parent being responsible for medical expenses of the other spouse or children. However, parents very often feel ashamed to let their children know that they are medically indigent. Very few of these parents wish to see their children investigated and evaluated. Their distaste for the procedure is such as to deter them from applying for benefits. The committee has recommended that the "responsible relatives provision" of the law be abolished.

Another problem in certifying people under MAA is timing. As it stands now, it often takes a month to have an individual receive certification of eligibility. It has been recommended by the committee that a speed up certification of eligible individuals be accomplished by eliminating protracted social welfare investigation procedures and accepting instead a formal certification of annual income as the basis for determination of eligibility. This certification should be filed annually—regardless of the state of the patient's health—to provide declaration of eligibility in advance of need for actual care.

The following summarizes the recommendations of the committee as regards changes in the New Jersey MAA Program:

1. Abolition of "relative responsibility" requirements.

2. Liberalization of income standards to make more aged eligible.

Amended to read:

2. Continuing review of income and liquid assets standards to make the MAA program as equitable as possible.

3. Prior certification of eligibility on the basis of attestation of income, perhaps on an annual basis.

4. Use of a voluntary private health insurance agency —such as Blue Shield and/or Blue Cross—as fiscal agents or underwriters of MAA benefits.

5. Retention of the lien law provision in view of the recommended elimination of "relative responsibility" requirements.

It is our belief that we *must* have even greater interest, concern, support, and participation by the individual physician—and greater education of the public—if Kerr-Mills is to achieve its full potential.

We must go forward with the experience gained, from mistakes made and successes achieved, to further strengthening of an already strong program, through local effort and national legislation.

I wish to thank all members of the committee and the staff for their diligent attendance and full cooperation in the transaction and completion of the year's work.

Approved as amended (page 354)

Conservation of Hearing and Speech

James H. Spillane, M.D., Chairman, Phillipsburg

(Reference Committee "G")

Your committee has continued to follow the progress of speech and hearing centers throughout the state and has continued to cooperate with the Division of Constructive Health of the State Department of Health as their school screening program goes into effect. We are continuing to work on the essentials of the screening procedures for the pre-school child and the adult, coupled with an educational program to instruct the public as to the proper procedure to follow when a hearing impairment is suspected.

The committee is encouraged by the number of communications received during the past year in regard to hearing aid salesmen and the type of advertising used. We plan to follow through on these communications and, through further study, to develop satisfactory recommendations.

Approved (page 355)

Conservation of Vision

Ralph E. Siegel, M.D., Chairman, Perth Amboy

(Reference Committee "G")

EYE HEALTH SCREENING PROGRAM

The Medical Society of New Jersey, through its Special Committee on the Conservation of Vision, sponsored the eighth consecutive statewide "Eye Health Screening Program" during the third week in September 1964. The program was supported by the New Jersey Academy of Ophthalmology and Otolaryngology, the New Jersey State Commission for the Blind, the New Jersey State Department of Health, and the New Jersey Hospital Association.

The number of participating centers for the detection of eye diseases was 72, and the total number of persons screened was 12,892—an increase of 58% over 1963. Of the number screened, 4.05% were tonometry positive or glaucoma suspects.

The Eye Health Screening Program exceeded the most optimistic forecasts for its success, and this outstanding public service project should be offered to the public again. Therefore, with the approval of the Board of Trustees, the committee is initiating plans for the 9th program for the week of September 19, 1965.

INDUSTRIAL EYE HEALTH SCREENING

The Western Electric Company of Newark, through its Medical Director, indicated a desire to participate in the 1965 screening program. It was approved that the eye health screening service to industrial employees at Western Electric Company should be conducted by the company as a pilot study in conjunction with the 1965 program.

Approved (page 355)

Maternal and Infant Welfare

John D. Preece, M.D., Chairman, Trenton

(Reference Committee "G")

The Special Committee on Maternal and Infant Welfare has continued its work of collecting and classifying the reports of maternal deaths in the state in 1964, in conjunction with the Division of Maternal and Infant Welfare of the New Jersey State Department of Health.

In the past the death of any woman while pregnant, or within 42 days of the termination of the pregnancy, was reported as a maternal death. In the future this time span will be increased, as recommended by the AMA, to include any death occurring up to 90 days after the termination of the pregnancy.

The committee will also work with Dr. Curtis Culp, Chief of the New Jersey Division of Infant and Maternal Welfare, in the drafting and publication of a new and improved questionnaire for the reporting of maternal deaths by the Field Physicians.

It is the opinion of the committee that a new questionnaire is long overdue, and that the work of the committee will be facilitated and improved by this new form of reporting.

Approved (page 355)

Mental Health

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "G")

In accordance with our established goals for 1964-65, the Committee on Mental Health is pleased to report progress in three of the four major areas:

1. In an effort to expedite the accomplishments and goals of the AMA Congress on Mental Health, we were instrumental in holding the first New Jersey State Congress on Mental Health at the New Jersey Neuro-Psychiatric Institute in Princeton on September 17, 1964. Even though we were disappointed in the number of physicians in attendance, it was encouraging to take this initial step in developing better climate for improved liaison between physicians and laymen in respect to the mental health of our state.

2. We have been unsuccessful in resolving the dilemma and confusion regarding the present system of physicians' reporting cases of convulsive disorders.

3. We believe progress has been made toward the legislative approval of the Mental Health Act of 1965 (A-128), and look forward to its early enactment.

4. With the continuation of educational programs of "psychiatry for the physician," as sponsored by the Passaic County Medical Society and the Carrier Clinic, we are encouraged that these long-established programs have spawned others which will soon become activated.

We continue to work closely with our state mental health planning authorities and their committees toward the realization of an ap-

propriate "Plan for Planning."

In furtherance of our activities, we have recommended to the Board of Trustees, through the Council on Public Health, that legislation be introduced to grant privileged communication between all physicians and their patients in New Jersey.

The committee expressed dissatisfaction with the dissemination of false and misleading information as contained in the popular comic strip "Little Orphan Annie" regarding the illegal incarceration and fearsome treatment in mental institutions, and recommended that its concern and possible consequence in these areas be brought to the attention of the membership through the pages of *The Journal.*

The committee discussed the obvious need for more educational programs for physicians within the profession dealing with psychiatry, and recommended that articles on mental health and illness be carried from time to time in *The Journal.*

Approved (page 355)

Rehabilitation

Elmer J. Elias, M.D., Chairman, Trenton

(Reference Committee "G")

The committee met on two occasions during the year to discuss matters referred to it by the Board of Trustees.

No further thought has been given to a directory of rehabilitative services inasmuch as it is felt that the State Department of Institutions and Agencies has not had sufficient time to compile data that they are gradually accumulating.

The committee is delighted to have initiated the recommendation which resulted in honor to one of our own members. The President's Committee on Employment of the Handicapped has cited Sol Parent, M.D., of Newark for meritorious service, in appreciation of his exceptional contributions in furthering the employment of the handicapped. The committee salutes Dr. Parent for this merited honor.

The Section on Medicine (of which your committee chairman is also the section chairman) will present at this annual meeting a Symposium on Rehabilitation of the Cardiac and Cerebral Vascular Accident. The symposium participants are outstanding in their field, and all members are urged to attend this excellent session.

Approved (page 355)

Contribution To Academy Library

The 1964 House of Delegates voted a special per capita assessment of $5 and directed that 25 per cent of the monies thus collected be donated to the Library of the Academy of Medicine of New Jersey, to help defray the expenses of its operations.

At the first session of the 1965 House of Delegates, President Calvin presented a check in behalf of MSNJ to Arthur Mangelsdorff, President of the Academy of Medicine, in the amount of $8,021.25.

Public Relations

John F. Kustrup, M.D., Chairman, Trenton

(Reference Committee "E")

Meeting in regular full session twice this year, the Council on Public Relations assumed responsibility for evaluating and suggesting programs and projects calculated to further the public relations of the Society as regards the relationship of doctor-and-doctor and doctor-and-patient, and the relationship of medicine, as an organized unit, with the general public. The council supervised the continuing and special projects and activities which routinely it administers.

CONTINUING PROJECTS

Following is a summary of the results of continuing projects carried out under the direction of the council, with the approval of the Board of Trustees:

1. Publication and distribution of:
   a. *Junior Health Hints* to secondary schools and public libraries . . . . . 3,000 copies
   b. *Health Hints* to the press, house organs, and other media on a semi-monthly basis 27 releases
   c. *Membership News Letter*, including the annual compilation of a bound, indexed set for each component society . . . . . 6 issues (as of March 31, 1965)
   d. *Periodic Newsletter* to cooperating agencies and individuals (as required). 1 issue (March, 1965)
2. Preparation and distribution of news releases for:
   a. *1964 (198th) Annual Meeting* . . . to dailies, wire services, and miscellaneous papers: (1) two-page general announcement; (2) five-page Golden Merit Award announcement; (3) eight-page inaugural address of the incoming president; (4) biographical sketch, with pictures, of incoming president; (5) three-page results of election session; (6) biographical sketch of second vice-president; (7) scientific exhibit awards; (8) honorary membership for Albert Bruce Sabin, M.D.; (9) three-page summary actions of the House of Delegates.
   b. *1964 Eye Health Screening Program* . . . (1) eleven-page release to dailies, weeklies, radio stations, house organs, cooperating agencies, etc.; (2) *Health Hint* to New Jersey newspapers and house organs for release during "Eye Health Week."
   c. *1964 Child Safety Week* . . . *Health Hint* to New Jersey newspapers and house organs for release during "Child Safety Week." Copy of Governor's proclamation to component societies, with the request that they stimulate further efforts to advance the program at local level.
   d. *Woman's Auxiliary Granted National Award of Honor* . . . under date of 7/17/64 to dailies and wire services.
   e. *Mrs. Asher Yaguda Elected First Vice-President of AMA* . . . under date of 7/17/64 to dailies and wire services.
   f. *Statement Approving Seton Hall Fact-Finding Committee* . . . under date of 9/8/64.
   g. *Statement on Development of Medical Schools* . . . under date of 10/20/64.
   h. *President's Reply to AFL-CIO Concerning Physicians and Pharmacies* . . . under date of 1/6/65 to dailies and wire services.
3. *Golden Merit Award Ceremonies:* A total of 44 members were recipients of the 1964 award, 21 of whom were present in Atlantic City. The reception immediately following the bestowal ceremonies again proved a highlight of the ceremonies, and the council with the approval of the Board of Trustees has agreed to continue it.
4. *Press Room at Annual Meeting:* Members of the council continue to assist in the activities of the press room in Atlantic City and are available to help arrange for necessary interviews. Advance releases are mailed from Trenton. Through the press room, information is distributed, interviews are arranged, and publicity pictures scheduled. With the Board's approval, the council has continued the procedure of distributing to the press, after the opening of the House, materials to be considered by the House of Delegates, as submitted to the House in its first session.

DRUG ADDICTION

The section of Resolution #1 (Middlesex County) adopted by the 1964 House requiring that MSNJ, "in conjunction with law enforcement agencies, engage in a statewide educational program to prevent drug addiction," was referred to the council. In furtherance of this resolution, the council has set up meetings with cooperating agencies and state agencies, to become more familiar with all aspects of the problem. The matter is under continuing study.

SPEECH TRAINING SESSIONS

With the approval of the Board, the council approved two pilot regional meetings (in Bergen and Essex Counties) for a speech training service—offered as a free public service by Smith Kline & French Laboratories—designed to help professional organizations in the health field to form public speaking and public relations programs. Because of the success of the pilot meetings, the council has en-

couraged other component societies to avail themselves of this service.

HEALTH CAREERS BOOKLET

At the request of the Woman's Auxiliary, the council—with the approval of the Board of Trustees—agreed to underwrite the cost of inserting four new listings in the Auxiliary's "Guide to Health Careers in New Jersey in the Medical and Para-Medical Fields" to include the careers of physical therapy, veterinary medicine, medical records librarian, and medical secretary.

GOLDEN MERIT AWARD

This year, the council will honor 37 recipients of the Golden Merit Award at ceremonies in Atlantic City. For the first time, the ceremonies will be held at 2:00 p.m. in the Rutland Room (first floor) of Haddon Hall, before the opening session of the House. The reception to honor the recipients and their families will follow in the Derbyshire Room.

NATIONAL (AMA) PROGRAMS

As the result of recommendations by the council concerning the AMA national educational program last fall, the Board of Trustees prepared a resolution (#18) for introduction at the AMA session in Miami Beach, the purpose of which was to establish a policy requiring that the AMA not commit itself to national programs without first giving constituent associations the opportunity of discussing and formally concurring in proposed national programs. The AMA Board of Trustees, through its chairman, declared the request for such meeting "utterly reasonable" and called a special conference of representatives of constituent associations in Chicago on December 13, 1964 to make plans for a new educational campaign.

The council reaffirmed this recommendation at its most recent meeting and urged that the Board up-date resolution #18 and reintroduce it at the AMA meeting in June.

KERR-MILLS PAMPHLET

In cooperation with the Board of Trustees, the council prepared the printing in pamphlet form of the question-and-answer resume of "Medicare versus Kerr-Mills" which was first presented in the October-November issue of the *Membership News Letter*. Copies of the pamphlet were mailed to component societies, for limited free distribution to interested members. Bulk supplies were made available to members at cost.

Approved (page 351)

EMERGENCY COVERAGE

The council continued its efforts to assure the maintenance of operationally adequate emergency call systems in all areas of the state. In July a conference was held with representatives of MSNJ, of the State Board of Medical Examiners, and the Attorney General to discuss the systems in all component societies. As the result of this conference, the council made contact with the component societies and requested an accurate and complete report of the programs presently in operation. A special subcommittee of the council was appointed to study the county reports and to offer itself to component societies as a consultant-group, to work out details locally. In an attempt to put into proper perspective the whole area of medical care, the council evolved a statement of basic concepts underlying the provision of professional medical care. This statement was submitted to the Board of Trustees; and after a series of amendments suggested by the Board, was approved in the form which follows:

BASIC CONCEPTS UNDERLYING THE PROVISION OF PROFESSIONAL MEDICAL CARE

Because medicine is an enlightened profession and not a mere business operation it imposes upon its members obligations of stern duty such as the businessman is not called upon to assume.

In our free society, the practice of medicine is built basically upon the doctor-patient relationship. The bond between the doctor and his patient is a dignified and profound human, contractual relationship, freely entered into by both contracting persons and imposing obligations on both.

The physician is free to choose whom he will serve; the patient is free to select the physician or physicians whose services he engages. Once the choice is made,

each owes to the other constancy and cooperation. Each is bound to the other, while the tie continues, by mutual rights and duties.

Once a physician has accepted a patient as his own, he is obligated to render service to that patient as such service is needed. If the physician foresees that for a period of time he will not be available to render service should need for it arise, he should make provision for a dependable substitute to render such service and should arrange that his patient be so informed. Of course, the patient is free to arrange to be served by another practitioner in the interim.

From all the foregoing it is clear that:

1. The patient should select and bind himself to the physician whom he wants as his own.

2. The physician should acknowledge his acceptance of the patient and should thereafter be committed to take care of that patient when his services are needed.

3. Against such times as he will not be available to render service to his patients, the physician should forewarn them or arrange with another qualified practitioner to substitute for him during the period of his own unavailability.

The relationship thus far does not involve the necessity of an organized system to cover medical emergencies. That necessity arises out of situations in which the patient either has no personal physician; or in which the patient is unable—because of his condition—to name his physician; or in which the patient's physician is incapable of taking the call and—because of the unexpectedness of his situation—has not arranged for a substitute to respond in his stead.

An emergency may be defined as "an unforeseen combination of circumstances which calls for immediate action." It should be noted that the circumstances of an emergency are unforeseen, but it does not follow that those circumstances are unforeseeable. It is within the power of intelligence to prepare against emergencies and thus to make preparations to minimize the distress or disaster which might ensue.

Emergencies of a really serious character require extensive and even heroic procedures that can be carried out only in hospitals, where teams of trained personnel and comprehensive facilities are available.

It is the responsibility of the local community to establish a system that will utilize hospital, police, or first-aid squad ambulances to transport victims of serious emergencies without delay to the nearest hospital, where adequate facilities exist and expert personnel stand ready to take the necessary measures.

In emergencies of this type, time is of the essence for the welfare of the patient. He should be rushed to the hospital at once, since an individual physician—no matter how promptly at hand—cannot improvise adequate substitutes for procedures possible only within the confines of a hospital.

Emergencies of a less serious type—in which the patient's condition is such as not to call for instant and extensive care— may be dealt with by the individual physician, summoned either directly or through the medium of the emergency call system maintained by the local medical organization.

These two emergency call systems should properly and cooperatively complement each other. When they do so, the community has good reason to feel that everyone who needs emergency medical care will receive it efficiently and dependably. However, individuals and firms that employ persons in work situations which may produce accidental injuries or induce exhaustion or collapse should be required to make specific provision for emergency care for their employees and should not depend on other programs.

Medicine is dedicated to providing care for people who need it. General understanding and mutual cooperation on the part of the physician, the patient, and the community, should make it possible to insure that, in ordinary or in emergency situations, no one who requires help will call for it in vain.

Approved (page 351)

Members are urged to familiarize themselves with these concepts.

Scientific Exhibit Awards

The Committee on Awards of the 1965 Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 15-19, announces the following selections for "Scientific Exhibit of individual investigation, judged on the basis of originality and excellence of presentation":

First Award

The Treatment of Scoliosis by Instrumentation and Fusion
Charles I. Nadel, M.D., New Jersey Orthopaedic Hospital, Orange

Second Award

Micro-Surgery of the Ear
I. M. Schnee, M.D., Barnert Memorial Hospital, Paterson

Honorable Mention

The Inhibition of Fibrinolysis Associated With Certain Hemorrhagic States
William M. Sweeney, M.D.; Charles J. Masur, M.D.; Edward DeRenzo, Ph.D.; Bergen Pines County Hospital, Paramus

Bilary-Hepatic Duct-Atresis
Julian A. Sterling, M.D., Albert Einstein Medical Center, Philadelphia, Pennsylvania

Disaster Medical Care

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "H")

During the year, the Special Committee on Disaster Medical Care has been alert to the days of international tension that could be suddenly reflected in pronounced activity by the medical profession. With this in mind it has observed the successful stockpiling of antibodies for disaster by immunization programs against tetanus, smallpox, measles, diphtheria, and poliomyelitis. The Medical Society of New Jersey has cooperated with the New Jersey State Department of Health and other organizations in the conduct of these programs, all of which must be maintained on a continuous basis.

Another item of importance was the receipt of the newer 1962 model Civil Defense Emergency Hospitals in New Jersey. These units are general hospitals having a capability of operation of 30 days in contrast with the older 1956 type that can function for only three days. There are 94 prepositioned Civil Defense Emergency Hospitals of both types throughout New Jersey. Medical Expansion Units are available to be stored with the older model hospitals to increase their operating capability.

It has been recommended that all of the newer CDEH units being released be functionally marked so that direct delivery to functional areas can be made to minimize or eliminate entirely the need for professional personnel to participate actively in setting up the units from the cases.

A most important item is the staffing of the Civil Defense Emergency Hospitals with adequate professional personnel. These hospitals are now organized and intended not only for function in war but also in major natural disasters. Each component medical society is strongly urged to procure and assign physicians to these hospitals and to do this in cooperation with the established hospitals of the community. In this process the disaster plans of the established community hospitals should not be disturbed.

Approved (page 356)

Medicine and Religion

Jerome G. Kaufman, M.D., Chairman, Maplewood

(Reference Committee "D")

The enthusiastic reception last year of the special program on medicine and religion held at the annual meeting resulted in publication of the entire transcription in the "Transactions Issue" of *The Journal* (July 1964). The Board of Trustees also authorized reprints, for distribution upon request.

Early in the year, the committee reviewed the the "Program Guide" prepared by the Ameri-

can Medical Association; and concluded that it could be accomplished basically, if not exclusively, at local levels. With the approval of the Board, each component society was requested to establish a Committee on Medicine and Religion, to achieve the cooperation of physicians and clergymen where indicated for the patient's benefit. It was suggested that in counties of limited population, a single county committee would suffice. In more populous areas, the desirability of establishing subcommittees in individual hospitals of the county was suggested.

Response from the counties was immediate. At the present time, the following component societies have functioning Committees on Medicine and Religion: Atlantic, Bergen, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Somerset, and Warren. Practically all the remaining counties plan to establish committees in the near future.

Some counties have already held very successful forum-type programs.

The state committee will serve as liaison between the AMA's Deparment of Medicine and Religion and the county committees. It is also available for consultation and advice.

These committees have been created as the result of an awareness, growing in recent years, of the necessity for utilizing spiritual and religious elements in the treatment of patients. Physicians recognize that these spiritual and religious factors play an important role in affording the patient total care.

Both the physician and the clergyman are concerned with the patient's situation in repect to his health, his family, his economic status, and all the other problems, fears, and challenges of his life. There has always been and there always will be need for the services of both clergyman and physician in this regard. The patient will be helped by the cooperation of his physician and his clergyman. There is need, therefore, for a close relationship between the ministers of medicine and of religion to bring about better therapy for the patient.

It is hoped that through county committees, physicians and clergymen of all faiths will be brought together for the study and discussion of their problems and common concerns for the total welfare of the patient.

Accepted (page 350)

Nursing Education and Recruitment

Jesse McCall, M.D., Chairman, Newton

(Reference Committee "H")

At the suggestion of the 1963 House of Delegates, MSNJ sought the assistance of other interested professional groups to effect the establishment of a Joint Committee on Nursing Education and Recruitment. The response was immediate and a joint committee —composed of representatives of the New Jersey Hospital Association, the New Jersey State Nurses' Association, the New Jersey Board of Nursing, the New Jersey League for Nursing, the New Jersey State Department of Education, and The Medical Society of New Jersey—was formed. The committee at once addressed itself to the study of what might be done to meet the great and growing need for nurses in our state.

Since my report to the House last year, the

joint committee met three times—either in full complement or through its designated subcommittee—to determine what approach should be made to better utilize existing educational facilities and/or to increase financial support of nursing education facilities in New Jersey. The committee agreed that consideration of stepping up nursing recruitment would have to wait upon the expansion of nurse-educational facilities and the augmentation of teaching staffs.

The committee realized that from sources presently available, no further funds—or, at least, no funds in sufficient amounts—could be realized or hoped for. It concluded that the solution of New Jersey's nurse shortage problem could not be met by the efforts and resources of the professions alone. Financial assistance from government—at federal and state levels—was indispensable if the critical needs of the people of New Jersey for present and future nursing care are to be met.

The committee agreed upon a letter which was sent to the Governor over the chairman's signature requesting his advice and assistance in providing the means which the professions could not themselves any longer supply. His response was immediate and enthusiastic.

On January 5, the Governor appointed Dr. Roscoe P. Kandle, Commissioner of Health, to set up the Governor's Task Force on Nursing, "to coordinate the State's efforts, together with the health, educational, and hospital professions in effecting short and long-term planning to increase the number of nurses in New Jersey." Representatives of all the professional groups of the joint committee were asked to serve on the Task Force.

The Governor's Task Force on Nursing has held two meetings, which resulted in these actions:

1. Endorsement of S-83—to include schools of professional nursing within the category of accredited colleges eligible for state scholarships. (This bill has been signed by the Governor and is now Chapter 5 of the Laws of 1965.)

2. Endorsement of the development and expansion of refresher training programs for inactive nurses.

3. Recommendation that the survey of "Nursing Needs and Resources" started by the New Jersey State Nurses' Association and other groups be completed; and that necessary funds be provided.

Three subcommnitees have been formed out of the body of the Task Force to study and evaluate the needs and conditions obtaining in diploma schools, collegiate schools, and community college programs.

Approved (page 356)

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "D")

The Committee on Retirement Plan for Physicians has been relatively inactive during the past year inasmuch as no new changes were made in the Keogh Plan nor have any positive regulations been made for the Internal Revenue Law relative to the incorporation of physicians and other self-employed plans.

On November 15, 1964, Dr. Moriconi appeared before the Board of Trustees with the recommendation that members be advised of the availability of the Keogh Plan. It was pointed out that an interpretation of the postal survey of the membership showed that seventy-five percent of the responding members employed one or no person in their of-

fices. It is felt by the Retirement Committee that these members would most benefit by the Keogh Plan.

Although no definite action was taken by the Retirement Plan Committee toward a specific plan, we can point out that many Plans are available and offered as approved by the Internal Revenue Service: the AMA Plan on a national scale, the Mercer County Plan in the State of New Jersey, and many excellent individual plans sponsored by various insurance companies, mutual funds, and special U. S. Savings Bonds.

At the meeting of the Board of Trustees held on February 24, Society's legal counsel presented a report which indicated that "Internal Revenue Service, in an unpublicized action, is determined that physicians cannot set themselves up as corporations for tax purposes. This, in spite of the fact that states—like New Jersey—have already passed special laws for that particular purpose. The IRS will not recognize pension plans of professionals who have incorporated."

RECOMMENDATION

Despite the relative quiet with relation to Retirement Plans this year, we still recommend the continuation of the Special Committee on Retirement Plan for Physicians as a clearing house for information and study of any future changes and thinking on retirement plans for physicians.

Approved (page 350)

Traffic Safety

William L. Sprout, M.D., Chairman, Salem

(Reference Committee "H")

During 1964-65, the Special Committee on Traffic Safety considered the study of alcohol involvement in fatal traffic accidents in 1961-63 conducted by the Division of Motor Vehicles, and reiterated its recommendations of previous years that new legislation should include automatic or "implied" consent by all licensed drivers to submit to blood or breath tests for alcohol content at the request of properly constituted authorities, with forfeiture of licenses for failure to comply. Such legislation should provide that the level of 100 milligrams of alcohol per 100 centimeters of blood be established as *prima facie* evidence that the person tested is under the influence of alcohol. The committee anticipates extension of the existing programs in which selected members of the Society act as advisors to the Division of Motor Vehicles in evaluating drivers with suspected medical limitations in their ability to drive.

Previous recommendations for the use of seat belts were extended as follows:

RECOMMENDATIONS

1. That The Medical Society of New Jersey urge the installation of seat belts in both front and rear seats of all passenger vehicles.

2. That the Board of Trustees urge all members of the Society to install and use front and rear seat belts in their cars and to be at pains regularly to use such seat belts as an example to the members of the public.

3. That the Society invite the Bar Association, Nurses' Association, Congress of Parents and Teachers, and members of the Woman's Auxiliary to cooperate in carrying out these recommendations.

4. That The Medical Society of New Jersey

request the State Department of Purchase to require adequate safety facilities in vehicles purchased by the State for official use, in compliance with standards and specifications being developed by the General Services Administration, purchasing agency for the Federal government.

Since the last meeting of the special committee, your chairman has been informed of the establishment of a Committee on Automotive Safety of the Essex County Medical Society. I feel that organization of such committees on the county or local levels should be encouraged; and area representatives, appointed to the Special Committee on Traffic Safety. By this means statewide action could be strengthened in support of approved legislation, for instance, and local attention could be focused on problems susceptible of local solutions in view or measures successfully adopted in other areas of the state.

Approved (page 356)

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1965 annual meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6 of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Atlantic County	M. Browne Holoman, Margate City; age 61
	G. Ruffin Stamps, Pleasantville; age 62
Bergen County	Grace Blauvelt-Welles, Orient, N. Y. (formerly Ridgewood); age 65
	Charles N. Dezer, Sea Girt; age 71
	Andrew F. Ferrari, Hohokus; age 61
	Alva Jenkins, Fort Lee; age 56
	William G. Mears, Sparta; age 67
	Vendela E. Olson, Hackensack; age 60
	Vincent Pellegrini, Fort Lee; age 55
	Henry E. Prall, Miami, Fla. (formerly Cliffside Park); age 57
Burlington County	Luther M. Hartman, Maple Shade; age 64
	Dean H. LeFavor, Riverton; age 65
	Clarence J. Poppen, Beachwood; age 66
Camden County	David F. Bentley, Jr., Pennsauken; age 75
	George P. Meyer, Haddon Heights; age 70
	Helen F. Schrack, Westmont; age 72
Cumberland County	Vincent Giacalone, Vineland; age 85
Essex County	Sanel Beer, Miami, Fla. (formerly Newark); age 79
	Charles D. Brunkow, Maplewood; age 69
	Laurence A. Cahill, Newark; age 81
	Ferdinand C. Dinge, East Orange; age 67
	Benjamin A. Furman, East Orange; age 82
	William H. Huber, Maplewood; age 71
	E. Clarence Kern, Essex Fells; age 69
	Elton B. Lafferty, Bricktown; age 61
	Ralph A. Pattyson, Orange; age 63
	Benjamin J. Silverstein, East Orange; age 76
	Earl R. Symes, Kearny; age 63
	I. Henry Young, West Orange; age 65
Mercer County	Geoffrey W. Esty, Princeton; age 61

Monmouth County	Benjamin Daversa, Spring Lake; age 61 Otto R. Holters, New York, N. Y. (formerly Asbury Park); age 69
Ocean County	Alice L. Clark, Riverview, Fla. (formerly Toms River); age 62 Harry F. Hoffman, Point Pleasant; age 81
Passaic County	Theodore T. Bender, Saddle River; age 78 Sidney C. Levine, Honolulu, H. I. (formerly East Paterson); age 73 Charles J. Murn, Paterson; age 83 Henry V. Weinert, Passaic; age 67
Union County	Thomas H. Leggett, Plainfield; age 73 Rolland D. Tomlinson, Westfield; age 88 Alice E. Tyndall, Westfield; age 74

Approved (poge 357)

Supplemental Report

The following additional nominations for election to emeritus membership were received from the component societies:

Bergen County	Joseph A. Rowe, River Edge; age 66 Edgar M. Tennis, Englewood; age 69
Cape May County	John B. Townsend, Ocean City; age 70
Essex County	Joseph G. Sutton, Montclair; age 71
Middlesex County	John D. Witmer, Lavallette; age 65
Union County	Beatrice Prazak-Lerman, Elizabeth; age 50

Approved (poge 357)

Recommendotion of reference committee: There is definite possibility thot on emeritus member might wont to return to proctice ot some dote in the future, or thot on emeritus member might decide to practice in onother stote ot some dote in the future.

It is uncleor as to how this situotion would be met, ond the committee recommends thot the Committee on Revision of Constitution ond Bylows review the possibilities of these eventuolities and possibly present an omendment in the future.

Approved (page 357)

Report of the Nominating Committee and Election

Jerome G. Kaufman, M.D., Chairman

May 16, 1965

OFFICE	TERM	FROM TO	NOMINEE and COUNTY
President-Elect	1 year	May 1965–May 1966	Joseph R. Jehl, Passaic
1st Vice-President	1 year	May 1965–May 1966	Louis K. Collins, Gloucester
2nd Vice-President	1 year	May 1965–May 1966	John F. Kustrup, Mercer
Secretary	1 year	May 1965–May 1966	Marcus H. Greifinger, Essex
Treasurer	1 year	May 1965–May 1966	Daniel F. Featherston, Monmouth
Trustees:			
1st District	3 years	May 1965–May 1968	Nicholas A. Bertha, Morris
2nd District	3 years	May 1965–May 1968	Thomas C. DeCecio, Bergen
3rd District	1 year	May 1965–May 1966	George E. Barbour, Somerset (To fill unexpired term of Dr. Kustrup)
5th District	3 years	May 1965–May 1968	Nicholas E. Marchione, Cumberland
11th Trustee	3 years	May 1965–May 1968	Jerome G. Kaufman, Essex

Judicial Councilors:			
2nd District	3 years	May 1965–May 1968	John L. Olpp, Bergen
5th District	3 years	May 1965–May 1968	John S. Madara, Salem
AMA Delegates:			
	2 years	Jan 1966–Dec 1967	Joseph P. Donnelly, Hudson
	2 years	Jan 1966–Dec 1967	Isaac N. Patterson, Gloucester
	2 years	Jan 1966–Dec 1967	Jesse McCall, Sussex
	1½ years	May 1965–Dec 1966	Frank J. Hughes, Camden
AMA Alternate Delegates:			
	2 years	Jan 1966–Dec 1967	Joseph R. Jehl, Passaic
	2 years	Jan 1966–Dec 1967	Robert E. Verdon, Bergen
	2 years	Jan 1966–Dec 1967	Louis S. Wegryn, Union
	1½ years	May 1965–Dec 1966	Matthew E. Boylan, Hudson
	1½ years	May 1965–Dec 1966	Jerome G. Kaufman, Essex
Delegates and Alternate Delegates to Other States:			
New York:			
Delegate	1 year	May 1965–May 1966	Joseph P. Donnelly, Hudson
Alternate	1 year	May 1965–May 1966	Paul H. Steel, Atlantic
Connecticut:			
Delegate	1 year	May 1965–May 1966	Lloyd A. Hamilton, Hunterdon
Alternate	1 year	May 1965–May 1966	Josiah C. McCracken, Atlantic
Administrative Councils:			
Legislation:			
1st District	3 years	May 1965–May 1968	Ludwig L. Simon, Essex
4th District	3 years	May 1965–May 1968	Meyer L. Abrams, Burlington
Medical Services:			
1st District	3 years	May 1965–May 1968	Francis J. Benz, Morris
6th Member	3 years	May 1965–May 1968	Frederick W. Durham, Camden
Public Health:			
1st District	3 years	May 1965–May 1968	Henry J. Konzelmann, Union
4th District	3 years	May 1965–May 1968	Anthony P. DeSpirito, Monmouth
Public Relations:			
1st District	3 years	May 1965–May 1968	S. William Kalb, Essex
6th Member	3 years	May 1965–May 1968	Howard C. Pieper, Monmouth
Standing Committees:			
Annual Meeting	3 years	May 1965–May 1968	George J. Kohut, Middlesex
Finance and Budget (from the House of Delegates)			
	3 years	May 1965–May 1968	Charles A. Landshof, Hudson
	2 years	May 1965–May 1967	John S. Van Mater, Middlesex
Medical Defense and Insurance			
	3 years	May 1965–May 1968	Jesse Schulman, Ocean
Medical Education	3 years	May 1965–May 1968	Frank S. Forte, Essex
Publication	3 years	May 1965–May 1968	James J. Fitzpatrick, Mercer
Woman's Auxiliary Advisory			
	3 years	May 1965–May 1968	Ralph K. Bush, Camden

All nominees were elected to the designated offices for the terms indicated.

Medical Service Administration of New Jersey

Harry N. Comando, M.D., President, Newark

(Reference Committee "C")

Medical Service Administration of New Jersey presents herewith its report for 1964 on the administration of the Medicare Program of the United States Government and the City of Newark Medical Plan.

MEDICARE PROGRAM

Medical Service Administration of New Jersey, on June 30, 1964, completed seven and one-half years as Fiscal Agent for The Medical Society of New Jersey in the administration of the physicians' portion of the Medical Care Program for dependents of members of the armed services. Under this program, dependent spouses and children of persons in active military service qualify for medical, surgical, obstetrical, and hospital services rendered by civilian physicians and hospitals at the expense of the Federal Government.

Contract

The final Medicare contract under which Medical Service Administration operated expired June 30, 1964.

As prime contractor to the Government, The Medical Society of New Jersey, at a meeting of its Board of Trustees on July 21, 1963, took action to designate Medical-Surgical Plan of New Jersey (Blue Shield) as its Fiscal Administrator to replace Medical Service Administration of New Jersey for the contract year beginning July 1, 1964 and ending June 30, 1965.

At meetings held by the Board of Governors of Medical Service Administration of New Jersey, and by the Board of Trustees of Medical-Surgical Plan of New Jersey on September 24, 1963, both Boards officially concurred in the action taken by the Board of Trustees of The Medical Society of New Jersey on July 21, 1963.

In consequence of the foregoing actions, the Agreement between Medical Service Administration of New Jersey and the Hospital Service Plan of New Jersey (Blue Cross) (whereby certain administrative services described in a subcontract between both organizations were being performed by Hospital Service Plan) was terminated on June 30, 1964.

Hence, beginning with July 1, 1964, all physicians' Medicare DA 1863-2 Claim Forms have been submitted to Medical-Surgical Plan of New Jersey (Blue Shield) for processing and payment.

Schedule of Allowances

The Schedule of Allowances for services performed under the Medicare Program, which was negotiated with the Department of the Army by the Special Medicare Committee of The Medical Society of New Jersey, has remained unchanged since January 1, 1960.

Administrative Expenses

The administrative expenses for the fiscal year from July 1, 1963 to June 30, 1964 were $21,297.94, at a cost of $3.33 per case.

Statistical Data

The claim experience for the first six months of 1964 — from January 1 to June 30 — is submitted herewith, along with the total claim experience of Medical Service Administration since the inception of the Program on December 7, 1956.

Detailed statistics for other years may be found in previous reports.

Period	*Claims Received*	*Declined*	*Returned Incomplete*	*Paid Claims*	*Paid Amount*	*On Hand*
Jan. 1/64–June 30/64	3,906	105	591	3,653	$ 303,474	210
Total since Dec. 7/56	67,754	2,311	17,127	48,093	$3,993,714	210

Approved (page 348)

CITY OF NEWARK MEDICAL PLAN

Twenty-six physicians participated during 1964 in the City of Newark Medical Plan which provides for medical services rendered in the homes of indigent and medically indigent persons by physicians of the patient's choice on a fee-for-service basis; where a patient, who fits this category, has no family physician, a telephone call to the Newark Division of Health will bring a physician to the home.

The classification of *indigent* is applied to those persons whose names appear on the Welfare Rolls of the City of Newark; the *medically indigent* are those who are considered by the City Division of Health as having income sufficient to meet the necessities of an adequate standard of living, but insufficient to pay for needed medical care.

Approved services rendered from January 1 to December 31, 1964, as compared with former years, were:

Relief	*1959*	*1960*	*1961*	*1962*	*1963*	*1964*
Number of cases.....	2,154	1,654	1,484	1,151	1,149	1,146
Value of services.....	$10,791	$7,417	$6,914	$5,329	$5,339	$5,736.50
Medically Indigent						
Number of cases.....	3,425	2,553	1,732	1,252	1,189	862
Value of services.....	$16,439	$11,979	$8,197	$5,999	$5,587	$4,420.00

In 1964, Medical Service Administration received from the City of Newark $11,172.15 for services rendered from November 1963 through October 1964. This amount was allocated as follows:

	For Physicians' Fees	*Plus 10% Service Charge*	*Representing Number of Visits*
Division of Welfare (Relief).....	$ 5,736.50	$ 573.65	1,146
Division of Health (Med. Ind.)....	4,420.00	442.00	862
	$10,156.50	$1,015.65	2,008

Medical Service Administration of New Jersey has endeavored to perform well and conscientiously all of the duties assigned to it in the implementation of the Medicare Program for the Federal Government and in the administration of the City of Newark Medical Plan. We believe we have succeeded, and we earnestly hope that the members of the medical profession in New Jersey share this opinion with us.

Approved **(page 348)**

New Business

With the consent of the House, the following motion was introduced at the final session as an item of new business:

That the House of Delegates of The Medical Society of New Jersey go on record as being opposed to the Medicare Bill, H.R.-6675, that the House record itself as approving the Eldercare Bill, H.R.-3727, and that this information be conveyed to the Senators and Representatives of the State of New Jersey by the Secretary of this Society.

Unanimously adopted

Medical-Surgical Plan of New Jersey

Nicholas F. Alfano, M.D., President, Newark

(Reference Committee "C")

Despite some tribulations during the past year, Medical-Surgical Plan carved out a record of continuing growth and service to our members in 1964. That this progress was accomplished in the face of adversities is due in no small part to the loyalty of our Participating Physicians, whose cooperation is a source of gratification to all of us in the Plan's management.

In April the Plan suffered an irreparable loss in the passing of Dr. Royal A. Schaaf, Chairman of the Board of Trustees, former Plan President and a Trustee since the Plan's founding in 1942. His loss was deeply felt by the medical profession, in which he stood as a giant, and the community at large, of which he was a revered citizen, as well as by the Plan to which he gave devoted leadership and guidance.

The Plan was indeed fortunate to find as Dr. Schaaf's successor a Trustee possessing the wisdom, professional eminence, and long-standing dedication to Blue Shield of Dr. Thomas J. White. Under his guidance we are looking confidently ahead to continued progress.

During a great part of 1964 the Plan suffered protracted "labor pains" from the introduction of new automated processes in claims processing. The more severe trauma, however, was to Participating Physicians and subscribers frustrated by delays that developed in processing claims and making payments, until necessary modifications could be made in the computer system. The forbearance exhibited by the great majority of physicians during those trying times—which happily are now behind us—was deeply appreciated by the Plan's management.

In a philosophical upset, one of the fundamentals on which Medical-Surgical Plan was founded was struck down by a Supreme Court decision. The court found unconstitutional the legal requirements for participation by 51 per cent of the eligible physicians in each New Jersey county, in order for the Plan to do business in the county. The outcome of the suit, which was brought by a prospective competitor of Blue Shield, has not resulted in an appreciable decline in participation, which affirms our confidence that support by the profession stems from what Blue Shield stands for as the creation of organized medicine. Loyalty cannot be legislated.

Belief in the Plan by the New Jersey community which it serves also was evidenced by substantial growth in membership during 1964. Midway in the year enrollment passed the 2.5 million-member mark, and at year's end had reached 2,538,668, a gain of 87,913 persons during the year. Medical-Surgical Plan now serves over 38 per cent of the total New Jersey population and continues to rank as fifth largest among all the Blue Shield Plans in the United States.

Premium income from subscribers reached a new high of over $48 million, against which claims of more than $44 million were incurred, also a record. Benefits to members represented a return of 92 cents on the premium dollar, a value unequaled in New Jersey medical cost protection.

The overall financial position of the Plan showed some retrogression from the previous year, due almost wholly to an unprecedented influx of claims for services rendered in 1963 but not billed for until 1964. While there is customarily a carry-over of this nature every year and allowance is made for it at year's end in calculating claims incurred, the volume in 1964 was nearly three times that of previous years.

To meet these claims and offset an operating loss of slightly over $100,000, it was necessary to deplete the Plan's reserves to the extent of $5.4 million. At the end of 1964 the reserves amounted to slightly over $5 million, representing approximately five weeks of normal operations.

On the plus side, noteworthy contributions were made to the coverage of members in 1964. Following enabling legislation, the Plan extended benefits to all members, at no additional premium, for certain oral surgical procedures performed in-hospital by a dentist; formerly payment for such procedures had been restricted to physicians. Another significant advance was the offering of Blue Cross-Blue Shield Extended Benefits Rider J to non-group members. The Rider, which had been available only to groups, received widespread acceptance from this new market; nearly half a million members now hold this additional coverage.

A major Plan project in 1964 was the Blue Shield Test of Performance Survey, in which Medical-Surgical Plan joined with 53 other Blue Shield Plans to make the largest study of its kind in the history of medical economics. The purpose was to determine to what extent Blue Shield payments are meeting physicians' charges, by a scientific random sampling of physicians' claims and confidential questionnaires to the physicians involved.

The Plan sent approximately 14,000 questionnaires to physicians, of which some 11,000 were returned to the survey headquarters in Chicago. The splendid cooperation of New Jersey doctors in thus assisting Blue Shield in its self-appraisal, and particularly the support given the survey by The Medical Society of New Jersey represents a valuable contribution to medical economics and is a source of deep gratification to the Plan.

New Jersey data developed through the study is under analysis by the National Association of Blue Shield Plans, which will make a series of reports to Medical-Surgical Plan. It is encouraging to note that data from the 54 Plans participating throughout the country indicate that, as a composite, Blue Shield pays 89 per cent of the costs of doctors' services to members holding the best group certificates of those Plans, and 82 per cent of charges under the most widely held group certificates.

Legislation helpful to Plan operations was enacted during the year, although not all of the needed measures gained passage. The Plan's enabling act was amended to permit entry into national account agreements with other Blue Shield Plans, so that Medical-Surgical Plan may enroll New Jersey employees of multi-location companies desiring uniform Blue Shield coverage in all their locations. Experience rating of such accounts also was authorized. Additional legislation enacted permits the Plan to issue master group contracts instead of individual subscriber contracts or certificates, and to issue joint contracts with Blue Cross.

Still lacking at this writing, but greatly desired, is legal authority to experience-rate groups located wholly within New Jersey. Without such authority the Plan remains at a rate disadvantage with commercial carriers, which by their ability to offer favorable rates to groups with good experience are siphoning off many of the Blue Plans' low risk groups, leaving the Plans with a growing percentage of high risk accounts. The necessary legislation has been introduced, and it is to be devoutly hoped that this relief will be granted.

The composition of the Plan's Board of Trustees was broadened in 1964 by the election of an eminent Doctor of Osteopathy and two outstanding business leaders. Dr. Edwin T. Ferren, treasurer of the State Board of Medical Examiners; Mr. Mortimer J. Fox, Jr., a vice president of Schering Corporation; and Mr. Edgar P. Eaton, Jr., president of the Carbone Corporation, are contributing to the direction of the Plan a breadth of knowledge and depth of experience that is most valuable.

The knowledge, experience, and dedication of all Trustees, Plan management executives, and employees will be called upon in full measure in the months and years ahead if we

are to maintain and increase Medical-Surgical Plan's proved leadership in the field. To the Society that fathered the Plan, and in particular to the Participating Physicians whose loyal support makes possible its service to the community, we pledge our utmost.

Comparative Balance Sheet December 31, 1964

Assets

	1964	*1963*
Cash on Hand and in Banks (Working Funds)	$ 301,709	$ 549,108
Investments	14,883,812	13,369,911
Accounts Receivable:		
Subscriptions	602,850	729,898
Workmen's Compensation	44,142	36,332
Federal Employee Program	393,984	562,238
Miscellaneous	14,105	2,134
Accrued Interest and Dividends Receivable	133,660	121,862
Total Assets	$16,374,262	$15,371,483

Liabilities

Claims Outstanding:			
Reported	$ 821,000	$2,420,000	
Unreported	7,688,000	4,570,000	
National Accounts	9,000	$ 8,518,000	$ 6,990,000
Unearned Subscriptions		2,358,053	2,083,560
Accounts Payable— Hospital Service Plan		145,731	485,619
Accounts Payable— Miscellaneous		277,241	193,482
Total Liabilities		$11,299,025	$ 9,751,661

Reserves

Securities Evaluation	$ 445,700	$ 400,000
Special Contingent	100,000	100,000
Unassigned	4,529,537	5,119,822
Total Reserves	$ 5,075,237	$ 5,619,822
Total Liabilities and Reserves	$16,374,262	$15,371,483

Annual Statistics 1964

TABLE I*

Paid 1964	*Total Services*	*% All Services*	*Payment*	*Percent*	*Payment Per Service*
Surgical	349,855	45.4%	$21,061,014	50.2%	$60.20
Medical	195,785	25.4	10,152,920	24.2	51.86
Obstetrical	48,022	6.2	6,670,720	15.9	138.91
Consultations	46,227	6.0	713,222	1.7	15.43
Anesthesia	131,548	17.0	3,356,337	8.0	25.51
Total	771,437	100.0%	$41,954,213	100.0%	$54.38

TABLE II

Distribution of Rider Services and Payment

	Total Services	*% All Services*	*Payment Amount*	*Percent*	*Payment Per Service*
Surgical	12,488	18.9%	$ 274,119	19.3%	$21.95
Medical	2,690	4.1	151,680	10.7	56.39
Diag. X-Ray	26,883	40.7	598,071	42.0	22.25
X-Ray Therapy	420	0.6	47,255	3.3	112.51
Physical Therapy	2,494	3.8	63,033	4.4	25.27
Pathology	21,021	31.9	288,350	20.3	13.72
Total	65,996	100.0%	$1,422,508	100.0%	$21.55

*Table I excludes Federal Claims Data.

TABLE III

Distribution of Earned Subscription Income

Earned Subscription Income	$48,338,312	100.0%
Incurred Claims	44,717,063	92.5
Operating Expense	4,309,589	8.9
Underwriting Loss	688,340	1.4

Distribution Per Dollar of Income

Surgical	46.4
Medical	22.4
Obstetrical	14.7
Anesthesia	7.4
Consultations	1.6
Operating Expense	8.9
Underwriting Loss	1.4

FEDERAL EMPLOYEE PROGRAM

The Plan's 1964 experience in the Federal Employee Program continued to be excellent. Although enrollment increased, claim incidence showed an appreciable decrease and operating expense went down, resulting in an operating gain more than double that of 1963. As in previous years, there was some broadening of coverage in 1964. On November 1, surgical removal of impacted teeth when rendered to a hospitalized bed patient became eligible for Plan payment. This service is not eligible when rendered to an out-patient at the hospital, or in the doctor's office.

Available medical days under the Federal Employee Program High Option Plan were increased from 120 to 365. The 30 medical days available under the Low Option Plan, however, remain the same.

Under both the High Option and Low Option Plans the limitations on medical care for nervous and mental conditions were removed. Following is a statement of income and expense, along with utilization statistics:

Income	$1,705,339	100.0%
Claims Incurred	1,588,600	93.2
	$ 116,739	6.8%
Operating Expense	71,844	4.2
Gain	$ 44,895	2.6%

PAID BASIS

Average Exposure (Persons)	118,105
Claim Incidence per 1,000 Persons Enrolled	218
Average Cost Per Case	$64.11
Number of Cases	25,795
Amount Paid	$1,653,600

PUBLIC RELATIONS PROGRAM

The past year presented the Plan's public relations operation with several new challenges, while at the same time its role in Plan communications was given increased effectiveness through broadened responsibilities.

Early in the year an extensive communications project was undertaken in connection with the Plan's participation in the Nationwide Blue Shield Test of Performance Survey. This study, to determine how well Blue Shield Plans perform in covering the cost of doctors' services for members, was the first of its kind ever attempted; hence an all-out program of information and education was mounted so that the need for the Survey would be appreciated, its mechanics understood, and the cooperation of the medical profession enlisted.

Toward those ends a wide spectrum of communications media were employed, including multiple mass mailings, news releases, advertisements, suggested editorials, poster displays, "Blue Shield Pulse," specially-designed envelopes, individual correspondence, and personal contacts. Internally, briefings were provided to Physician Relations, Central Inquiry, Telephone, and Correspondence Units.

That the informational objectives were achieved was manifest in the cooperation exhibited by the medical profession, through the completion and return of some 11,000 Survey questionnaires. Equally significant was the profession's response to the patient audit phase of the study; less than 1 per cent of the doctors involved refused the Plan permission

to query patients in validating data obtained from the doctors.

Throughout the year the continuing program to build public appreciation of the contribution made by Participating Doctors and its significance to service benefits subscribers were given added impetus. An effective newspaper advertising campaign was conducted, backed up by an attractive educational leaflet provided to Participating Doctors for waiting room distribution. The role of the Participating Doctor in making Blue Shield protection possible was further highlighted in numerous brochures, leaflets, bill stuffers, posters, letterheads, and other printed material reaching subscribers and potential subscribers.

Another significant project was promotion of the Rider J offering to non-group subscribers, together with informing the profession of this expansion of the popular coverage. Here an even greater diversity and depth of media were utilized to show-case the Rider, which received wide non-group acceptance.

The Plan's management in 1964 increased the scope of the Public Relations area of responsibility by assigning to it accountability for all Medical-Surgical Plan literature, printed material, and advertising, including the Blue Shield content of combined Blue Shield-Blue Cross material. Internally, this permitted better procedural coordination; externally, added emphasis was placed upon delineation of the Plan's identity and its distinctive character and functions.

The nature of the Public Relations function carries it into all Plan areas where there are communications with one or more publics, whether they be subscribers, physicians, the general public, the Board of Trustees, or others. The increasing complexity of Blue Shield's role in the viable field of health economics and the task of putting that role into its proper perspective with the various publics call for close Public Relations coordination with the Plan's Officers, operating sections, and Trustees, as well as with Hospital Service Plan. The whole-hearted cooperation received from these sources and from The Medical Society of New Jersey is gratefully acknowledged.

There are indications that situations developing in 1965 could make it a crucial year for Medical-Surgical Plan, and hence for its Public Relations. When and if such problems arise, we have every confidence that they will be met and effectively resolved, through the cooperative efforts of the Plan's Public Relations Office, Management, and Trustees.

CLAIMS INCURRED

Year	Amount
1964	$44,717,000
1963	40,991,000
1962	37,753,000
1961	34,575,000
1960	31,516,000
1957	22,886,000
1954	13,992,000
1951	6,527,000
1948	1,204,000
1945	208,000
1942	5,000

CASES PER 1,000 PERSONS ENROLLED

Year	Incidence
1964	205
1963	193
1962	182
1961	177
1960	166
1956	143
1954	126
1951	112
1948	96
1945	86
1942	40

PHYSICIAN RELATIONS REPORT

The Physician Relations Section's primary function is the maintenance of a "two way" street of communication between the Plan and the medical profession. The objectives of liaison, cooperation, and exchange of information were accomplished by the utilization of several avenues of communication including a field program, telephone calls, and correspondence.

During 1964, the Section was forced to restrict its field program and intensify its office activities in order to cope with the increase in telephone calls and correspondence arising from the Plan's expansion of its computer program. During this period, the field representatives managed to make a number of field contacts, including the maintenance of information

desks in the physicians' lounge of twenty-two hospitals; addressing medical staff meetings in nine hospitals; conducting several meetings of medical assistants; and manning Plan exhibits at several medical conventions. In addition, visits were made to numerous physicians' offices and other meetings, including those of specialty societies and county medical societies, were attended.

The Section handled 17,311 incoming and outgoing telephone calls during 1964. The majority of the incoming calls during the Spring and Summer related to delays in payments. In numerous instances, delays were caused by physicians submitting incorrect taxpayer identifying numbers, not submitting a number at all, or changing a number after using it for several weeks. Tracing and correcting these problems was a time-consuming procedure. In addition, the Section answered 4,815 pieces of correspondence.

A gratifying observation by Physician Relations was the patience and cooperation shown by the overwhelming majority of the practicing physicians of New Jersey during the trying period of expansion of the computer program. We believe that this patience and cooperation will be rewarded by faster and more efficient claims processing in the years to come.

Every personal communication made by the Section, whether by field contact or telephone, hopefully helped the medical profession to better understand Blue Shield problems, policies, and procedures. The chain is evident: Communication generates understanding—understanding generates cooperation — cooperation generates a more efficient Blue Shield Plan, which will be of greater service to the citizens and physicians of New Jersey.

In 1965, we will make every possible effort to enhance this "two way" street of communication between the Plan and the medical profession.

MEDICARE PROGRAM

Medical-Surgical Plan on July 1, 1964, took over the fiscal administration of payments to physicians under the government's Medicare Program for dependents of U.S. uniformed services personnel. As prime contractor to the Government for the implementation of the physicians' portion of the Medicare Program, The Medical Society of New Jersey on July 21, 1963 had designated the Plan as its Fiscal Administrator to replace Medical Service Administration of New Jersey.

The Board of Governors of Medical Service Administration and the Board of Trustees of Medical-Surgical Plan concurred in the action by the Medical Society. As of July 1, 1964, Contract #DA-05-114-MD-34 was executed by the President on behalf of the Trustees of Medical-Surgical Plan of New Jersey, as was a bond in support of an advance payment of $100,000.

A modification to the contract, changing the method of computing anesthesia fees from a time basis to relationship to the surgical procedure, was executed following approval by the Medical Society.

Effective August 1, 1964, anesthesia fees (except for obstetrical deliveries and tonsillectomies) have been calculated on the basis of 20% of the payment for the surgical procedure, or $15.00—whichever is greater. The $20 fees for obstetrical anesthesia involving delivery by manipulation and for tonsillectomy anesthesia, either local or general, remain unchanged.

The Schedule of Allowances for the Medicare Program was negotiated between representatives of the Medical Society and the U.S. Government as representing fair compensation for services rendered to patients with an annual income of $4500, the average for members of the uniformed services. Except for the modification of anesthesia fees, the Schedule has remained unchanged since 1960.

STATISTICAL DATA

Following is the claim experience for the last six months of 1964 as administered by Medical-Surgical Plan:

CLAIMS

Period	*Received*	*Declined*	*Returned Incomplete*	*Paid Claims*	*Paid Amount*	*On Hand*
July 1 to Dec. 31, 1964.....	4,165	172	942	3,009	$243,912	370

Claims for the first six months of 1964 were administered by Medical Service Administration of New Jersey as follows:

Period	*Received*	*Declined*	*Returned Incomplete*	*Paid Claims*	*Paid Amount*	*On Hand*
Jan. 1 to June 30, 1964.....	3,906	105	591	3,653	$303,474	210

Period	*Received*	*Declined*	*Returned Incomplete*	*Paid Claims*	*Paid Amount*	*On Hand*
Total Medicare Claims 1964:	8,071	277	1,533	6,662	$547,386	370

COMPARATIVE SUMMARY OF OPERATIONS

	1964		1963	
Subscriptions Earned*.....	$48,338,312	100.0%	$44,613,365	100.0%
Less:				
Claims Incurred**.....$44,717,063		92.5	$40,990,924	91.9
Operating Expenses***.. 4,309,589		8.9	3,950,841	8.8
	49,026,652	101.4%	44,941,765	100.7%
(Loss) from Underwriting Operations...	(688,340)	(1.4%)	(328,400)	(.7%)
Income on Investments.....	569,560		434,277	
Operating Gain or (Loss) for the Year...	$ (118,780)		105,877	

* The gain of $3,724,947 in subscriptions earned reflects gains in enrollment, which increased by 87,913 during the year.

** The rise of $3,726,139 in claims incurred is attributable to increased exposure from larger enrollment and to increased incidence, which rose from 193 per 1,000 persons to 205.

*** The increase of $358,748 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of $237,045 and a rise of $121,703 in Medical-Surgical Plan direct expenses. Based on subscriptions earned, total operating expense increased by one tenth of one percent.

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

Reserves at January 1.....		$5,619,822		$5,362,169
Operating Gain or (Loss) for the Year.....		(118,780)		105,877
		5,501,042		5,468,046
Plus: Reserve Adjustments				
Non-Admitted Assets.....	($12,962)		$81,016	
Unrealized Capital Gains.....	42,474		47,760	
Claim Reserve.....	(500,000)		(200,000)	
Rider "J" and State of N. J. Income.....	44,683		223,000	
		(425,805)		151,776
		$5,075,237*		$5,619,822

* The decrease of $544,585 in reserves for the protection of Plan Subscribers is caused by a net operating loss of $118,780 and reserve adjustments totaling $425,805.

NEW JERSEY PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

December 31, 1964

	County	Total Eligible Phys.	Participating Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.	Non-Participating Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.	% P. P. as of 12-31-64	% P. P. as of 12-31-63
1.	Atlantic	222	204	163	18	14	6	3	18	16				2	91.8	92.1
2.	Bergen	1036	647	533	53	33	14	4	389	358	18	4	1	8	62.4	64.5
3.	Burlington	209	191	151	28	8	2	2	18	13	4			1	91.3	88.7
4.	Camden	599	518	351	126	27	5	9	81	72	4	1		4	86.4	86.5
5.	Cape May	70	66	50	11	3	2		4	1	3				94.3	91.5
6.	Cumberland	120	115	100	4	5	4	2	5	3	1			1	95.8	97.4
7.	Essex	1673	1329	1184	49	66	16	14	344	317	7	1	3	16	79.4	80.2
8.	Gloucester	121	104	68	22	9	3	2	17	13	3			1	85.9	85.6
9.	Hudson	709	565	504	10	37	6	8	144	136		2	2	4	79.6	80.3
10.	Hunterdon	59	55	54	1				4	4					93.2	95.2
11.	Mercer	455	371	338	10	14	4	5	84	77	5			2	81.5	81.6
12.	Middlesex	422	320	282	14	15	8	1	102	90	1	1	2	8	75.8	78.6
13.	Monmouth	441	333	293	16	13	4	7	108	97	3	2		6	75.5	77.9
14.	Morris	378	309	261	21	9	8	10	69	60	2	2		5	81.7	82.4
15.	Ocean	143	109	97	7	3	1	1	34	31				3	76.2	80.0
16.	Passaic	609	445	384	18	30	4	9	164	151	3	2	1	7	73.0	74.9
17.	Salem	49	48	40	5	2	1		1	1					97.9	97.8
18.	Somerset	142	107	98	3	3	1	2	35	32			1	2	75.3	81.6
19.	Sussex	50	46	39	4	1	1	1	4	4					92.0	91.8
20.	Union	767	540	462	30	37	7	4	227	208	6	1		12	70.4	72.6
21.	Warren	49	47	43	2		2		2	2					95.9	95.9
22.	Out of State	280	268	231	31	2	3	1	12	12					95.7	96.5
	TOTALS	8603	6737	5726	483	331	102	95	1866	1698	60	16	10	82	78.3	79.5

N. J. PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY TYPE OF PRACTICE

December 31, 1964

	Type of Practice	Total Eligible Phys.	Participating Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.	Non-Participating Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.	% P. P. as of 12-31-64	% P. P. as of 12-31-63
1.	Anes	344	185	176	9				159	155	4				53.7	56.4
2.	Derm.-Syph	123	98	98					25	25					79.6	80.1
3.	Int. Med	1039	821	812	9				218	215	3				79.0	82.1
4.	Neur. Surg	38	17	17					21	21					44.7	50.1
5.	Obst.-Gyn	580	272	269	3				308	308					46.9	50.0
6.	Ophth	261	172	170	2				89	89					65.9	68.2
7.	Orth. Surg	208	137	135	2				71	71					65.8	66.6
8.	Otol	162	98	96	2				64	64					60.5	62.6
9.	Path	110	88	86	2				22	22					80.0	82.1
10.	Ped	435	399	398	1				36	36					91.7	92.0
11.	Phys. Med	15	11	11					4	4					73.3	69.2
12.	Plast. Surg	21	7	7					14	14					33.3	38.4
13.	Analy. Labs	112	102				102		10				10		91.0	—
14.	Proct	32	22	18	4				10	10					68.7	67.7
15.	Psy. & Neuro	241	167	166	1				74	73	1				69.2	70.1
16.	Radiology	169	128	124	4				41	41					75.7	79.2
17.	Surg	688	514	505	9				174	172	2				74.7	75.4
18.	Thor. Surg	18	8	8					10	10					44.4	38.8
19.	Urol	155	81	79	2				74	74					52.2	53.8
20.	Chiropody	347	331			331			16			16			95.3	95.1
21.	General	3328	2984	2551	433				344	294	50				89.6	88.2
22.	Dentists	177	95					95	82					82	53.6	—
	TOTALS	8603	6737	5726	483	331	102	95	1866	1698	60	16	10	82	78.3	79.5

1964 BOARD OF TRUSTEES

Chairman of the Board
Thomas J. White, M.D.

First Vice-President	*Second Vice-President*	*Secretary-Treasurer*
Jerome G. Kaufman, M.D. (1967)	Rudolph C. Schretzmann, M.D. (1965)	John S. Thompson (1965)
Charles W. Barkhorn, M.D. (1966)	Edgar P. Eaton, Jr. (1967)	Jesse McCall, M.D. (1967)
Irving P. Borsher, M.D. (1966)	Joseph I. Echikson, M.D. (1967)	Duane E. Minard, Jr. (1965)
Robert G. Boyd (1966)	Edward T. Ferren, D.O. (1967)	Sidney I. Simon, Ph.D. (1966)
Charles H. Calvin, M.D. (1966)	Mortimer J. Fox, Jr. (1967)	Edward W. Sprague, M.D. (1965)
Charles L. Cunniff, M. D. (1966)	Joseph M. Keating, M.D. (1967)	Charles O. Tyler, M.D. (1965)
Andrew P. Dedick, Jr., M.D. (1966)	Elton W. Lance, M.D. (1967)	Robert E. Verdon, M.D. (1966)
Joseph P. Donnelly, M.D. (1967)	Samuel J. Lloyd, M.D. (1967)	Gustave E. Wiedenmayer (1966)

ADVISORS TO THE BOARD OF TRUSTEES

	Appointed	*Term as Board Member*
F. Clyde Bowers, M.D.	1963	1961–1963
Harry N. Comando, M.D.	1959	1942–1958
William F. Costello, M.D.	1958	1948–1958
William E. Dodd, M.D.	1952	1944–1952

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D. 1945–1945	William K. Harryman, M.D. 1944–1945	* Royal A. Schaaf, M.D. 1942–1964
* Theophilus H. Boysen, M.D. 1944–1945	Sigurd W. Johnsen, M.D. 1950–1951	* Norman M. Scott, M.D. 1942–1950
Lewis W. Brown, M.D. 1949–1954	* Augustus S. Knight, M.D. 1942–1948	Reuben L. Sharp, M.D. 1950–1951
* William J. Carrington, M.D. 1942–1943	* Thomas K. Lewis, M.D. 1942–1949	James J. Spencer, M.D. 1957–1961
* Patrick H. Corrigan, M.D. 1952–1958	Paul Mecray, Jr., M.D. 1953–1961	* Carl K. Withers 1952–1961
* Samuel A. Cosgrove, M.D. 1944–1953	Glennis S. Rickert, M.D. 1959–1963	David L. Yunich 1962–1963

* Deceased.

OFFICERS

Thomas J. White, M.D.
Chairman of the Board

Nicholas F. Alfano, M.D.
President and Medical Director

John S. Robinson
Executive Vice-President

John S. Thompson
Secretary-Treasurer

ENROLLMENT REPORT

Medical-Surgical Plan entered the 60's with a membership total of 1,954,215 persons covered under one basic contract and one of three rider offerings. At year-end 1964 the Plan had enrolled 2,538,668 persons whose coverage is contained within one of eleven "basic" contracts, with rider coverage available under one of five rider programs for Group and Direct Payment subscribers. Entering the second half of the decade, the Plan finds itself in the midst of a market becoming increasingly complex.

The year 1964 saw the introduction of two new programs to the enrollment structure of the organization. In mid-1964 legislation was passed which permitted the Plan to enter into National Account programs on an experience rated basis. Later in the year, a new program of benefits was offered to our Direct Payment population through the introduction of Rider J coverage. Both programs have been influential in the current year's growth, although the full potential of the National Account program has not as yet been felt.

During 1964 the Plan's membership rolls increased by a total of 87,913 persons from the

38,705 contracts added, bringing the volume of contracts in force to just under one million subscribers (999,973). Group business, in total, showed a net gain of 62,180 members through the 23,317 contracts added during the year. This gain was spread over all classes of coverage except the basic-only certificate. In the area of ridered contracts, 47,212 contracts were added, resulting in 130,800 more persons being covered by these benefits. The basic-only contract, on the other hand, displayed a net loss for 1964 of 33,059 contracts (96,857 persons).

The Direct Payment Rider J Program offered to our enrolled Direct Payment population resulted in an addition of 66,000 subscribers under this extended benefit offering. These contracts, with effective dates in late 1964 and early 1965, add approximately 130,000 members to those covered by these benefits. Aside from this offering, the Direct Payment categories produced a net total of 15,488 contracts for the Plan in 1964, supplying coverage to an additional 25,733 persons. As with Group, the introduction of a ridered program caused the basic-only contract to suffer a reduction in exposure. The Non-Group basic contract lost 9,713 members while the Left-Group basic contract was decreased by 10,486 members.

ENROLLMENT GROWTH

Year	Enrollment
1964	2,538,668
1963	2,450,755
1960	2,080,582
1957	1,711,834
1954	1,196,804
1951	669,906
1948	236,604
1942	4,131

Approved (page 348)

Honor For Dr. Parent

On May 17, 1965, Dr. Calvin, making a presentation to Dr. Sol Parent said:

It is the established custom each year for the President of the United States to confer citations on physicians of the nation who have distinguished themselves in encouraging employment of the handicapped. This year, Doctor Sol Parent of Newark, was nominated for the award by the New Jersey Rehabilitation Commission and endorsed by The Medical Society of New Jersey.

Doctor Parent has been Consultant to the New Jersey Rehabilitation Commission's Disability Determination Service since 1957. He served as Chief Medical Advisor to the Commission's special project on independent living rehabilitation. In both capacities, he has constantly provided higher professional leadership and guidance to the State Rehabilitation Commission's program. In addition, he has contributed valuable training to the Commission's professional rehabilitation staff in the fields of medical terminology and relationship of disability to the employment potential.

It is now my pleasure to present this citation from the President's Committee on the Employment of the Handicapped — (wording on citation):

Citation for meritorious service conferred upon Doctor Sol Parent in appreciation for the excellent contribution in furthering the employment of handicapped.

(Signed) Raymond Male
for
(and) Governor Hughes

Harold Russell
for
Dated February 16, 1965 President Johnson

RESOLUTIONS

#1

Public Relations Personnel

From the Essex County Medical Society

(Reference Committee "A")

Whereas, The Medical Society of New Jersey does not have an experienced public relations or communications man on its staff or a public relations or communications firm on a consultant retainer basis; and

Whereas, the following State Societies do have full time public relations consultants on their staffs for their conventions and other activities: Connecticut, New York, Pennsylvania, Illinois, Massachusetts, Michigan, Minnesota, North Dakota, Ohio, Tennessee, Texas, Virginia, Washington, and Hawaii; and

Whereas, three surrounding State Societies — Pennsylvania, New York, and Connecticut — have PR personnel that are available for component society problems, as well as State Society use; and

Whereas, it is financially infeasible for many smaller component medical societies to hire experienced public relations or communications consultants; and

Whereas, releases issued by one component society often appear in radio and newspaper media which cross county lines; and

Whereas, on key matters that concern the press a State Society PR consultant could clear the releases at state level, which would assure that the public media would get the same prompt answers and releases from all component societies; and

Whereas, preventive PR is like fire prevention in that you can either develop a positive preventive program ahead of time, or you can spend your time attempting to put out grass fires; and

Whereas, experienced PR communication personnel can develop such a positive program; and

Whereas, the imminent passage of a Medicare type plan will present many problems in communication which need central, unified publicity releases; therefore be it

RESOLVED, that The Medical Society of New Jersey hire experienced full time public relations or communications personnel, or retain the services of a public relations or communications firm to handle its convention and other activities, as well as draft and implement a full time, year-round public relations program; and be it further

RESOLVED, that these public relations personnel be available to draft releases upon request from a component county medical society; and be it further

RESOLVED, that these professional communications personnel work directly with any component county medical society upon request when a specific problem with the public, such as emergency medical service, arises locally.

Resolution as presented not approved (page 344); but principle involved approved.

Recommendations of reference committee adopted:

That the Board of Trustees give serious consideration to supplying additional staff members to the Executive Director to help particularly with the problems encountered with regard to the workings of the Judicial Council, the Council on Legislation, and the Council on Public Relations.

That component societies be encouraged to make arrangements at the county level to improve their public relations efforts, each county to act according to its own needs and to determine if such improvements can be made with its own personnel and members, or whether formal public relations help is required. (page 345)

#2

The Society for the Relief of Widows and Orphans of Medical Men of New Jersey

From the Essex County Medical Society

(Reference Committee "A")

Whereas, The Society for the Relief of Widows and Orphans of Medical Men of New Jersey has been in existence for eighty years, and during this period of time, has provided for the care and protection of widows and orphans of deceased members; and

Whereas, physicians have taken care of their own who were in need of assistance, and should continue to do so; and

Whereas, there is a continuing need for relief, assistance, encouragement, and protection of widows and orphans of medical men of New Jersey who are in difficult circumstances; and

Whereas, The Society for the Relief of Widows and Orphans of Medical Men of New Jersey is the only organization of its kind in this State, the same being patterned upon the original Society founded in London, England, in the early seventeenth century; therefore be it

RESOLVED, that The Medical Society of New Jersey urge and recommend that all its members actively participate in the work of the Society for the Relief of Widows and Orphans of Medical Men of New Jersey by becoming members of this Society, thus helping their own families and the families of their brother physicians; and be it further

RESOLVED, that members of The Medical Society of New Jersey be informed through *The Journal* that applications and information may be obtained by writing: The Society for the Relief of the Widows and Orphans of Medical Men of New Jersey, P.O. Box 95, Belleville, New Jersey.

Approved (page 345)

#3

Allocation of Funds for New Jersey Medical Schools

From the Bergen County Medical Society

(Reference Committee "B")

Whereas, we now have two medical schools in our State that could well use additional funds; and

Whereas, moneys raised from our members in the past have not been allocated to those schools; and

Whereas, the members of The Medical Society of New Jersey have not been consulted concerning such allocations, because of deliberate disregard of their expressed wishes in recent years; now therefore be it

(This paragraph withdrawn)

RESOLVED, that each member of The Medical Society of New Jersey be assessed five dollars this year, and one half the sum realized be allocated to each of the two medical schools in New Jersey; and be it further

RESOLVED, that this resolution be forwarded to The Medical Society of New Jersey to be presented for adoption by the House of Delegates of The Medical Society of New Jersey at the annual meeting in 1965.

Approved as amended (page 347)

#4

MSP Contract Inequities

From the Middlesex County Medical Society

(Reference Committee "C")

Whereas, the individual members of The Medical Society of New Jersey have a vital interest in the actual contracts of the Medical-Surgical Plan of New Jersey; and

Whereas, the provisions of the contracts of the Medical Surgical Plan of New Jersey exhibit several inequities working to the detriment of both participating physicians and the patient; therefore be it

RESOLVED, that the Middlesex County Component Medical Society demands that the following changes be effected by the Medical-Surgical Plan of New Jersey:

1. When the patient has major medical and/or multiple medical-surgical type coverage, either through non-profit or indemnity plans or both, the participating physician shall be entitled to his usual fee or to the value of the total medical-surgical type coverage, whichever is less;

2. In third party actions, the participating physician shall not have his fee restricted by the Medical-Surgical Plan of New Jersey, but shall be entitled to his usual fee or the combined value of the fee paid by the Medical-Surgical Plan of New Jersey plus any judgment for medical services awarded the patient, whichever is less;

3. When necessary operative and non-operative care is rendered by one or more participating physicians, said operation either incidental or secondary to the total non-operative care of the patient, the physician or physicians rendering the care shall be entitled to receive both the medical and the surgical fees authorized under the schedule of payments of the Medical-Surgical Plan of New Jersey.

(This paragraph deleted)

Approved as amended (page 348)

#5

Community Mental Health Centers

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, the medical profession has assumed leadership in working to provide adequate facilities for treatment of the mentally and emotionally ill, through various programs and endeavors, such as sponsorship of two national Mental Health Congresses, numerous state and local Mental Health Congresses; and

Whereas, physicians particularly are aware of the existence of great quantitative and qualitative shortages in comprehensive facilities for the treatment of mentally and emotionally ill children and adults who are not able to pay for private psychiatric care; and

Whereas, HR-2985 and S-513 (the National Mental Health Bills) provide for the implementation of previously enacted legislation endorsed by the medical profession through its spokesmen on the national level; and

Whereas, HR-2985 and S-513 are in the best American tradition of federal aid to provide incentive for state and local effort to support needed services; and

Whereas, HR-2985 and S-513 afford no new or unique departure in the relationship of federal, state, or local government to provision of psychiatric treatment services; and

Where, HR-2985 and S-513 provide for federal assistance in meeting costs of *initial* operations for community mental health centers, which assistance is specifically limited to a period of four years, with the percentage of federal assistance mandatorily decreased each of those four years from a high of 75%, to 60%, to 45%, to 30%, to zero; and

Whereas, HR-2985 and S-513 have been endorsed by the American Psychiatric Association and its component district branches; and

Whereas, support of HR-2985 and S-513 by the medical profession would be of great value in again demonstrating to the American public the profession's interest in, and concern for, the welfare of the mentally and emotionally ill and of the total citizenry of our Nation; now therefore be it

RESOLVED, that the Bergen County Medical Society go on record in support of the enactment of HR-2985 and S-513; and be it further

RESOLVED, that the House of Delegates of The Medical Society of New Jersey be urged to record itself as concurring in the action of the Bergen County Medical Society; and be it further

RESOLVED, that New Jersey's delegation to the American Medical Association be instructed to introduce and support a resolution calling upon the American Medical Association likewise to encourage the enactment of HR-2985 and S-513.

Approved (page 351)

#6

General Practice

From the Cumberland County Medical Society

Withdrawn at first session by Dr. Nicholas E. Marchione, Cumberland County spokesman.

#7

Reinstatement of Full Tax Deductibility of Medical Expenses of the Elderly

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, the House of Representatives has recently passed and sent to the Senate of the United States a bill entitled HR-6675, commonly known as "Medicare", for further action by the Senate; and

Whereas, this bill, as currently written, includes a change in the Internal Revenue regulations which would end the current fully tax deductible status of medical and drug expenses for those over 65 years of age; and

Whereas, this would cause certain individuals who are chronically ill and require long term medical care to request financial aid for the medically indigent from the state and county, although they could possibly pay for these expenses if a full tax deduction were allowed; and

Whereas, the avowed purpose of this bill — to help those over 65 years of age financially unable to pay for their medical expenses — would be impaired by this change of Internal Revenue regulations; now therefore be it

RESOLVED, that this Society go on record as opposing this provision of HR-6675 and that, further, this Society so notify Senator Case and Senator Williams and Senator Byrd of the Senate Finance Committee; and be if further

RESOLVED, that a copy of this resolution be sent to The Medical Society of New Jersey, to be presented for adoption by the House of Delegates of The Medical Society of New Jersey at the 1965 annual meeting and to each of the component county societies for appropriate action.

Approved (page 351)

#8

Discrimination

From the Essex County Medical Society

(Reference Committee "F")

Whereas, the members of he Medical Society of New Jersey as physicians hold that there is no basis in medical science for discrimination because of race, religion, or place of national origin; and

Where, the members of The Medical Society of New Jersey have in the past decried such discrimination; and

Whereas, it is apparent that such discrimination continues to exist within the United States; therefore be it

RESOLVED, that The Medical Society of New Jersey continue to be unalterably opposed to any discrimination in the field of medicine because of race, creed, color, or national origin, whether in patient care, physician opportunity, or professional organization; and be it further

RESOLVED, that the American Medical Association be urged to use all its influence to end discriminatory racial exclusion policies by some county medical societies as contrary to the law of the land and the ethics of our profession.

Approved (page 353)

#9

Recognition of Alcoholism as a Disease

From the Bergen County Medical Society

(Reference Committee "G")

Whereas, chronic alcoholism is on the rise in Bergen County as well as in all New Jersey and ranks among the four major health threats in our nation, along with heart disease, cancer, and mental illness; and

Whereas, organized medicine, which recognizes the disease concept of alcoholism, must be in the forefront of the universally accepted diverse approaches in the prevention, treatment, and rehabilitation of the chronic alcoholic; now therefore be it

RESOLVED, that the Bergen County Medical Society – recognizing chronic alcoholism as a progressive, destructive, pathologic condition affecting a great segment of our population – assume responsibility and active leadership in fostering an awareness of this condition and in leading a comprehensive constructive rehabilitation program in Bergen County; and it further

RESOLVED, that a copy of this resolution be submitted to the House of Delegates of The Medical Society of New Jersey to the end that it record its approval and support of the principles and objectives set forth herein.

Approved (page 355)

#10

The Academy of Medicine of New Jersey

From the Board of Trustees

(Reference Committee "B")

The following resolution from the Academy of Medicine is referred to the House:

Whereas, one of the missions of The Medical Society of New Jersey is to promote the continued education of its members; and

Whereas, a well-stocked medical library is an indispensable instrument of such a program; and

Whereas, the only large and generally accessible medical library in our State is the one at The Academy of Medicine of New Jersey; and

Whereas, in recognition of this, The Medical Society of New Jersey has helped support the Academy library through a grant made for 1965; and

Whereas, the Academy continues its intellectually enriching educational seminars for the increasing needs of the entire medical profession of New Jersey; and

Whereas, those services cannot be maintained without the continued support of the Medical Society; therefore be it

RESOLVED, that The Medical Society of New Jersey contribute to the Academy of Medicine and its library, and that there be allocated a sum of $2.50 per year for each dues-paying member of The Medical Society of New Jersey.

Not approved (page 347). Suggested that any surplus monies from the Bicentennial Fund be turned over to the Library of the Academy of Medicine, and that their request be reconsidered next year when the bicentennial fund may no longer be required.

RECOMMENDATION OF THE BOARD OF TRUSTEES

That a contribution to the Academy in 1966 be the same as that adopted by the House for 1965 (25% of special $5.00 per capita assessment).

Approved (page 347)

#11

Approval by Individual Diagnosis

From William Yudkoff, M.D., Delegate
Richard L. Franklin, M.D., Member of the
Hudson County Medical Society

(Reference Committee "C")

Whereas, a hospital utilization program known as "Aproval by Individual Diagnosis" (AID) has been proposed by the Hospital Service Plan of New Jersey (N. J. Blue Cross) as a means of reducing the length of hospital stay; and

Whereas, the principal burden of making this program workable will fall on the individual physician by making him completely responsible for filling out the forms required to insure hospitalization longer than initially approved; and

Whereas, the use of a schedule of days for any disease based on averages (or any other statistical method) interferes with the individual practice of medicine, since it implies that any variance from the allotted stay is due to factors under the absolute and sole control of the attending physician; and

Whereas, in part because of the above reasons, but mainly because the program is obviously cumbersome, impractical, and doomed to fail to achieve its purpose despite the full cooperation of all parties; and such failure without question will then be attributed, solely, to the physician; therefore be it

RESOLVED, that The Medical Society of New Jersey is opposed to the adoption of the "Approval for Individual Diagnosis" program.

Disapproved (page 348)

#12

Blue Cross-Component Society Liaison Committee

From William Yudkoff, M.D., Delegate
Richard L. Franklin, M.D., Member of the
Hudson County Medical Society

(Reference Committee "C")

Whereas, both the Hospital Service Plan of New Jersey (Blue Cross) and The Medical Society of New Jersey are desirous of a program for maximum utilization of hospitals for necessary hospital care and for elimination of unnecessary hospitalization or undue stay; and

Whereas, the establishment of individual Hospital Utilization Committees composed of staff physicians has not achieved this purpose, as evidenced by the proposal of the "Approval by Individual Diagnosis" (AID) program; therefore be it

RESOLVED, that The Medical Society of New Jersey recommend to the Hospital Service Plan of New Jersey that it establish a liaison committee with each county medical society to review those instances in which the (Blue Cross) investigators feel that there has been unnecessary or prolonged hospitalization; and be it further

RESOLVED, that in every county committee each hospital be represented by assigning physicians from its staff.

Disapproved (page 348)

#13

Routine "PAP" Test

From the Camden County Medical Society

(Reference Committee "G")

Whereas, during the last quarter of a century vaginal exfoliative cytology has withstood the scrutiny, criticism, and objective evaluation of hundreds of scientists, pathologists, and clinicians; and

Whereas, the United States Department of Health, Education, and Welfare has statistically shown that mortality from cancer of both uterine cervix and corpus has decreased by almost half without a comparable change in incidence, thus reflecting the results of earlier diagnosis including the frequent use of vaginal cytology; and

Whereas, the acceptance of the "Pap" test by women and their physicians has been encouraging; and a Gallup Poll in the United States showed that in 1961, 30 out of every 100 women reported that they had the "Pap" test at least once and by 1963, 48 out of 100 had had the test; therefore be it

RESOLVED, that The Medical Society of New Jersey recommend to all its members the importance of including vaginal cytology as part of the periodic physical examination of all female patients.

(This action was already been taken by the California Medical Association)

Approved (page 355)

#14

Medicare—HR 6675

From John J. Thompson, M.D. and Frank Y. Watson, M.D. Delegates from Essex County

(Reference Committee "E")

Whereas, the practice of Pathology, Radiology, Anesthesiology, and Physical Medicine are branches of the practice of medicine (and not hospital services) just as are such professional services as Surgery, Internal Medicine, etc., and have been so recognized repeatedly by the American Medical Association, all state medical societies, federal, state, and local governmental medical services, the various courts of our land, and other agencies of government; and

Whereas, the services of Pathologists, Radiologists, Anesthesiologists, and Physiatrists are professional services and not hospital services, and therefore do not belong in the portion of a federal Medicare bill solely designed to offer hospital benefits; and

Whereas, the House of Representatives of the Congress of the United States has quite properly excluded the payment of professional fees to Pathologists, Radiologists, Anesthesiologists, and Physiatrists as hospital service benefits in HR 6675; and

Whereas, the American Hospital Association and all of its State Hospital Associations are

now devoting all of their efforts to persuading the Senate of the United States to include the fees of Pathologists, Radiologists, Anesthesiologists, and Physiatrists in the hospital service benefits section of the Medicare legislation now before it; and

Whereas, inclusion of the fees of Pathologists, Radiologists, Anesthesiologists, and Physiatrists in the hospital service benefits of a Federal Social Security financial law would establish the precedent for defining all professional services performed in hospitals as hospital services (the ultimate in socialized medicine); therefore be it

RESOLVED, that The Medical Society of New Jersey reaffirms that the practice of Pathology, Radiology, Anesthesiology, and Physical Medicine are branches of the practice of medicine and that the services of Pathologists, Radiologists, Anesthesiologists, and Physiatrists are professional services and not hospital services, and therefore fees for the services of these physicians do not belong in any benefits paid for hospital services from any source; and be it further

RESOLVED, that The Medical Society of New Jersey so notify the distinguished members of the Congress of the United States now representing the State of New Jersey; and be it further

RESOLVED, that The Medical Society of New Jersey so inform the American Medical Association and all of the state medical societies, and request that they reaffirm their support of the sentiments expressed in this resolution, and so notify the Congressmen representing their respective states; and be it further

RESOLVED, that The Medical Society of New Jersey urge all of its members to notify Senators Case and Williams and their respective Representatives of their support of this resolution and request that fees for professional services of Pathologists, Radiologists, Anesthesiologists, and Physiatrists be kept in the voluntary portion of the bill covering fees for professional services rather than placed in that portion solely designed to offer hospital services.

Approved (page 351)

#15

State Medical Library

From the Mercer County Medical Society

(Reference Committee "A")

Whereas, the branches and departments of government, the Legislature, the Department of Health, the Department of Agriculture, the State Boards of Medical and Dental Examiners, The Medical Society of New Jersey, and the New Jersey Pharmaceutical Association all center in Trenton, the capital of New Jersey; and

Whereas, the work of these organizations would be made more effective if a complete medical library were readily available; and

Whereas, a state facility could avail itself of source material from the Federal Government; and

Whereas, the establishment and support of a complete medical library can best be effected under the asupices of the State of New Jersey; therefore be it

RESOLVED, that The Medical Society of New Jersey recommend that the State of New Jersey establish and maintain a medical library in Trenton, the State Capitol.

Tabled (page 345)

#16

Rehabilitation Commission Fee Schedule

From the Mercer County Medical Society

(Reference Committee "F")

Whereas, the New Jersey Rehabilitation Commission has established a surgical fee schedule which is approximately two-thirds of the Blue Shield schedule; and

Whereas, the Blue Shield schedule has been jointly accepted by The Medical Society of New Jersey as a substandard fee; and

Whereas, other services rendered to indigent or tax-supported individuals are not subject to such a substandard fee; therefore be it

RESOLVED, that The Medical Society of New Jersey request the New Jersey Rehabilitation Commission to revise its fee schedule upward to meet the level of a standard fee in New Jersey.

Not approved (page 352)

#17

Auto Drivers' Licenses

From Andrew C. Ruoff, III, M.D., Delegate from Passaic County

(Reference Committee "H")

RESOLVED, that The Medical Society of New Jersey endorse the recommendation of the New Jersey Committee on Trauma of the American College of Surgeons and strongly recommend that the State of New Jersey follow the example of the State of North Carolina and revise its drivers' licenses to include space for immunization information and other medical identifying data on the reverse side of the automobile drivers' licenses.

Approved (page 357)

#18

Section 6, AMA Principles of Medical Ethics

From J. Bruce Henriksen, M.D., Delegate from Ocean County
John C. Clark, M.D., Delegate from Monmouth County

(Reference Committee "E")

Whereas, Section 6 of the AMA Principles of Medical Ethics declares: "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterio-

ration of the quality of medical care."; and

Whereas, quality medical care cannot long survive without a freedom of choice under the free enterprise system of medical practices; and

Whereas, compulsory social insurance medicine limits the freedom of choice and substitutes socialism for the free enterprise system; and

Whereas, the substitution of any socialistic system of medical care for the free enterprise system would prove detrimental to the public welfare by producing a deterioration of quality medical care; and

Whereas, experience has taught that there will always be supervision and unwarranted control over the practice of medicine and the manner in which medical services are to be provided under any system of compulsory government medical care; therefore be it

RESOLVED, by the House of Delegates of The Medical Society of New Jersey in regular session assembled the 15th day of May, 1965, that it is ethical, proper, and desirable for physician-members to protect the interest of those they serve by continuing to care for them free from the dictates of any agency or third party constituted or designated to implement any compulsory social insurance program of medical care; and be it further

RESOLVED, that the New Jersey Delegates to the American Medical Association introduce and actively support this resolution at the next session of the American Medical Association House of Delegates.

Not approved (page 352)

#19

County Judicial Committees

From Thomas C. DeCecio, M.D., Delegate from Bergen County

(Reference Committee on Constitutions and Bylaws)

Whereas, some county medical societies have *voting lay members* on their Judicial Committees; and

Whereas, the Constitution and Bylaws of The Medical Society of New Jersey makes no provision for committee membership to anyone other than members of The Medical Society of New Jersey; and

Whereas, the intimate relationship between the Judicial Committees of the county medical societies and the Judicial Council of The Medical Society of New Jersey is such that there should be no inconsistency in the Constitutions and Bylaws of the two; and

Whereas, such inconsistency as exists exposes *voting lay members* of the Judicial Committees to legal jeopardy; and

Whereas, the assurance of legal protection by our present insurance company does not protect such *voting lay members* should a change of company occur; and

Whereas, the lay member was included at the behest of the AMA; therefore be it

RESOLVED, that appropriate amendment of the Constitution and Bylaws of The Medical Society of New Jersey be made to achieve unequivocable protection of *voting lay members* of the Judicial Committees of the county medical societies.

Referred to standing Committee on Revision of Constitution and Bylaws for study and report at the 1966 annual meeting (page 358)

#20

Approval by Individual Diagnosis

From the Middlesex County Medical Society

(Reference Committee "C")

Whereas, the members of The Medical Society of New Jersey are vitally concerned with aiding the control of hospital and medical costs by preventing unnecessary lengths of hospital stay; and

Whereas, the increasing costs of hospital care are due mainly to factors other than over-utilization under the control of the physician; and

Whereas, hospital review committees composed of physician members are presently working to control the length of hospitalization of the patient; and

Whereas, it is self-evident that only an insignificant number of physicians would fail automatically to approve the duration of hospital stay of their patients by certification of the medical necessity for such stay under the present AID program; and

Whereas, a requirement that such certification be done will unnecessarily increase the work by the physician, the hospital, and the Blue Cross-Blue Shield Plan, thus increasing the financial cost to the patient; therefore be it

RESOLVED, that the members of The Medical Society of New Jersey oppose completely the wasteful plan for such physician certification of patient hospitalization and demand that this part of the AID program be revoked immediately; and be it further

RESOLVED, that if this part of the AID program is not revoked, the members of The Medical Society of New Jersey hereby automatically certify the medical necessity for the length of hospitalization of their patients, and will not add further certification in the case of any individual patient; and be it further

RESOLVED, that the members of The Medical Society of New Jersey recommend that hospital review committees be encouraged to function more efficiently by cooperative action among the State Blue Cross-Blue Shield Plans, the County Blue Cross-Blue Shield Committees, and local hospital review committees, especially in those hospitals whose utilization figures are well above the average in the State of New Jersey; and that the AID averages be utilized in this endeavor; and be it further

RESOLVED, that additional measures be promoted by the Blue Cross-Blue Shield plans to conserve hospital costs along the following lines: payment by Blue Shield for office procedures in all contracts, thus avoiding large Blue Cross costs; development of a new formula of payments to hospitals by Blue Cross to encourage economy of operation; removal of the present discounting of hospital bills in compensation cases; cooperative efforts with local, county, and state legislative bodies to pay full costs of indigent patients from general tax funds, thus decreasing the costs to insured patients; and encouragement of and cooperation with hospitals to place them on a seven day a week basis.

Disapproved (page 349). However, recognizing some constructive suggestions in the resolution the reference committee presented the following alternate version embracing the views of the reference committee:

Whereas, the members of The Medical Society of New Jersey are vitally concerned with aiding the control of hospital and medical costs by preventing unnecessary lengths of hospital stay; therefore be it

RESOLVED, that additional measures be promoted by the Blue Cross-Blue Shield Plans to conserve hospital costs, along the following lines: payment by Blue Shield for office procedures in all contracts, thus avoiding large Blue Cross costs; development of a new formula of payments to hospitals by Blue Cross to encourage economy of operations; removal of the present discounting of hospital bills in compensation cases; cooperative efforts with local, county, and state legislative bodies to pay full costs of indigent patients; and encouragement of and cooperation with hospitals to place them on a seven day a week basis

Approved (page 349)

#21

Subsidized Voluntary Health Insurance Programs

From Nathan S. Deutsch, M.D., Delegate from Union County

(Reference Committee "E")

Whereas, we in the medical profession have always been for the best of medical care for all the people of the country; and

Whereas, we the members of The Medical Society of New Jersey have pioneered in furnishing medical care to those unable to afford the cost as typified by ERA; and

Whereas, there is a group of people over the age 65 who cannot afford the cost of modern medical care; and

Whereas, there are people in the low income bracket who also cannot afford the cost of modern medical care; and

Whereas, the blind, infirm, orphans, etc. are in the same category; and

Whereas, the clinics as we know them today are passe and antiquated; therefore be it

RESOLVED, that we support a voluntary health insurance program subsidized by State and Federal Funds as needed to take care of the costs of medical care for the above mentioned groups.

Superfluous, not approved (page 352)

#22

Against Boycotting Medical Care Legislation

From John Winslow, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, it appears that legislation providing for a Federally-oriented program of providing health care for the elderly will be passed by the national Congress; and

Whereas, organized medicine is now making constructive suggestions designed to improve this legislation to provide the best possible care to the patient while preserving the traditional concepts of the private practice of medicine; and

Whereas, no sensible policy concerning the implementation of legislation of this type can be developed until the final draft of this legislation is available for study; therefore be it

RESOLVED, that The Medical Society of New Jersey makes the following commitments:

1. That it supports the position expressed on May 14, 1965, by American Medical Association President Donovan Ward strongly opposing the organization and approval of any medicare boycotts by physicians; and

2. That it will urge and expect its members to participate in whatever medical care program results from the eventual passage of the legislation for health care of the elderly embodied in what is now known as HR 6675, the "Social Security Amendments of 1965."

Not approved (page 352)

#23

Areawide Planning for Medical Facilities

From John Winslow, M.D., Delegate from Essex County

(Reference Committee "F")

Whereas, the American Medical Association has repeatedly passed resolutions urging that medical societies and individual physicians should not only cooperate with, but exert leadership in, the formulation and operation of regional planning bodies, while being alert to resist legislation which might make voluntary planning become mandatory; and

Whereas, very few physicians in New Jersey appear to know much about, and most certainly are not involved in, areawide planning for medical facilities, with only a few of them represented on any existing planning boards or groups; and

Whereas, physicians are in the best position to know what their patients' actual needs are in the line of medical care, though practicing physicians are more often than not left out, perhaps by default, of third-party medical care planning; and

Whereas, by not actively participating, very often physicians are allowing regional planning to go in directions which might not seem to be in the best interests of proper medical care for their patients; and

Whereas, New Jersey has recently started on the implementation of regional planning groups in a determined way, such as with the newly formed Health Facilities Planning Council for New Jersey; and

Whereas, The Medical Society of New Jersey is a member of said Health Facilities Planning Council for New Jersey, has three top-rank physicians on its board, and has contributed to its financial support by a "one-time contribution of $5,000," (page 256); therefore be it

RESOLVED, that The Medical Society of New Jersey affirm its continued official support and membership in the Health Facilities Planning Council for New Jersey and that it plan to pay on a yearly basis whatever the cost will be for a full participating membership in said organization; and be it further

Amended to read: RESOLVED, that The Medical Society of New Jersey affirm its continued official support and membership in the Health Facilities Planning Council for New Jersey; and be it further

RESOLVED, that The Medical Society of New Jersey urge that each of its component societies set up a permanent, functioning committee called by some appropriate title, such as Committee on Areawide Planning for Medical Facilities, and arrange that said committee be given such powers of cooperation, leadership, and promotion of areawide planning of medical facilities as the governing body of the county society would designate or approve from time to time; and be it further

RESOLVED, that The Medical Society of New Jersey urge each hospital in New Jersey, if it has not already done so, to set up an official committee, with membership from the medical staff, administration, and the trustees, to determine policy and cooperate with regional planning movements in its local, regional, and state areas; and be it further

RESOLVED, that The Medical Society of New Jersey urge all of its members to cooperate with regional planning groups and give active support to the concept, in addition to helping set up and participate in local planning groups in all areas of the State.

Approved as amended (page 353)

#24

President's Commission on Heart Disease, Cancer and Stroke

From John Winslow, M.D., Delegate from Essex County

(Reference Committee "G")

Whereas, medicine in the United States, though it may have some imperfections, still brings recognition as being the best in the world, and it is maintaining that leadership with its present systems of practice, as they evolve from many different angles and approaches; and

Whereas, existing medical centers and institutions are already struggling with inadequate funds and lack of enough trained personnel, and any lessening of funds and personnel would be calamitous; and

Whereas, the President's Commission on Heart Disease, Cancer and Stroke has come up with *A National Program To Conquer Heart Disease, Cancer and Stroke* which, among other things, proposes to reorganize just about all of the present methods of medical practice and care, not only for the mentioned diseases but for all illnesses; and, in so doing, it would cause much arbitrary medicine to be practiced, with much loss of self-criticism and inventiveness, such as a loss at a local level of a willingness to try a "different" approach to a medical problem; and

Whereas, the Commission's report portends bigger and more fundamental changes in American medicine than any other legislation yet brought up for consideration; therefore be it

RESOLVED, that the MSNJ completely support the laudible *purposes* of the President's Commission on Heart Disease, Cancer and Stroke in its attempt to further increase medical knowledge and therapy of these crippling diseases and to help those who suffer from them; and be it further

RESOLVED, that the MSNJ disagrees with many of the methods as outlined by the Commission for the approach to the above problems, feeling that they would bring a disastrous lessening of the good care which most of our hospitals are now giving as they keep surprisingly abreast of the most recent advances in medical knowledge and therapeutics; and be it further

RESOLVED, that the MSNJ more specifically urges that the bolstering-up and extension of already existing facilities be the first order of attack on a local level, with the construction of completely new different facilities being allowed only where none now exist; and be it further

RESOLVED, that MSNJ urges, next in order, that improvement be made in the methods of getting medical knowledge and technics down to a local level, which is the place where these ubiquitous diseases are found, thus avoiding the transportation of patients over great distances, and away from the regular medical care, to large and resultingly "cold" institutional centers where there would no longer be any cohesion with the patients' local medical care, to which they would ultimately have to return; and be it further

RESOLVED, that the MSNJ forward to the American Medical Association its support of the recent AMA Staff Report, *A National Program to Conquer Heart Disease, Cancer and Stroke,* JAMA: 192: 299-301, April 26, 1965, and urges that the AMA do all in its power to change the present contemplated government approach.

Rewritten and condensed by reference committee as follows (page 355):

Whereas, the President's Commission on Heart Disease, Cancer, and Stroke has recommended a program to establish throughout the United States diagnostic and treatment centers for these specific diseases; and

Whereas, the effecting of this program would radically change the private practice of medicine in these fields; and

Whereas, this program would establish a deadening centralization of the practice in the areas of heart disease, cancer, and stroke; therefore be it

RESOLVED, that even though The Medical Society of New Jersey recognizes the praiseworthiness of the endeavors of the President's Commission on Heart Disease, Cancer, and Stroke to further medical knowledge and improve treatment of these crippling diseases, it nevertheless is troubled by the vague outlines of the Commission in its approach to this problem, feeling that implementation of them would bring a disastrous lessening of good medical care which is now available in our hospitals; and be it further

RESOLVED, that The Medical Society of New Jersey approves the recent AMA Staff Report, A National Program to Conquer Heart Disease, Cancer and Stroke, JAMA; 192: 299-301, April 26, 1965, and supports the AMA in its position on this matter.

Approved (page 355)

Chairmen of Councils and Committees 1965-1966

Air Pollution	Roslyn Barbash, M.D.
Annual Meeting	Jerome G. Kaufman, M.D.
Cancer Control	John L. Olpp, M.D.
Child Health	Robert E. Jennings, M.D.
Chronically Ill and the Aging	Matthew E. Boylan, M.D.
Conservation of Hearing & Speech	
Conservation of Vision	Ralph E. Siegel, M.D.
Credentials	Marcus H. Greifinger, M.D.
Disaster Medical Care	Jack R. Karel, M.D.
Finance and Budget	Thomas C. DeCecio, M.D.
Honorary Membership	F. Clyde Bowers, M.D.
Legislation	Jesse McCall, M.D.
Maternal and Infant Welfare	John D. Preece, M.D.
Medical Education	Sherman Garrison, M.D.
Medical Defense and Insurance	Daniel F. Featherston, M.D.
Medical Services	Nicholas E. Marchione, M.D.
Medical Student Loan Fund	Luke A. Mulligan, M.D.
Medicine and Religion	Jerome G. Kaufman, M.D.
Mental Health	Robert S. Garber, M.D.
Occupational Health, Rehabilitation, Workmen's Compensation	Joseph A. Lepree, M.D.
Publication	George B. Sharbaugh, M.D.
Public Health	John B. Fuhrmann, M.D.
Public Relations	Harry F. Suter, M.D.
Retirement Plan for Physicians	Nicholas E. Marchione, M.D.
Revision of Constitution and Bylaws	Louis F. Albright, M.D.
Traffic Safety	William L. Sprout, M.D.
Woman's Auxiliary Advisory	George O. Rowohlt, M.D.

#25

Compulsory Medical Care Insurance for the Entire Population

From John Winslow, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, many physicians realize that there are many unmet insurance needs for medical care for the entire population, rather than just for the elderly people; and

Whereas, the unmet need appears to be particularly in the realm of prolonged or catastrophic illness; and

Whereas, the AMA is now taking the lead, in planning and furthering programs for medical care insurance, having changed completely its old opposition approaches; and

Whereas, American medicine strongly wishes to further the work of the voluntary private insurance plans; therefore be it

RESOLVED, that The Medical Society of New Jersey urge the AMA to take the lead in furthering the broadening of adequate medical care insurance coverage for the entire population, rather than just the so-called elderly, who are often less in need than those who are much younger, with growing families; and be it further

RESOLVED, that The Medical Society of New Jersey urge the AMA to give consideration to a compulsory insurance plan type of approach, based on the voluntary private insurance companies, with various co-insurance and pooling features, which insurance plans might have all or many of the following features:

1. That certain basic minimum plans for hospital and other care be determined, perhaps based on or similar to the eldercare ideas, with the voluntary insurance companies giving the minimum or greater coverage; and

2. That the insurance be tied in with the income tax report forms for every person in the land, with the Social Security tax number being used; and

3. That those who can afford to pay for the said basic insurance coverage be obligated to do so and attach a certificate from the insurance company with their income tax return, stating that the insurance premium has been paid for that year; and

4. That, if the citizen does not pay, or refuses any insurance plan for his own or his family's medical care, he be obligated, as with the New Jersey Automobile Responsibility Insurance Act, to pay, along with his income tax return, into a pooled fund which could later take over, by appropriate means, said person's medical payments when he finds himself unable to meet them; and

5. That, if the citizen is unable to pay at all or completely pay for the basic insurance, all of which would be appropriately determined by his income tax statement, he then would be given coverage by a government financial support for the needed premium amounts; and

6. That "poor risk" individuals would be "assigned" to the various private insurance companies, by some coordinating agency made up of the insurance companies and/or the pooled fund agency.

Disapproved (page 352)

REFERENCE COMMITTEES

Reference Committee "A"

Elbert H. Pogue, M.D., Chairman

Reference Committee "A" met on Sunday, May 16, 1965, with the following members present: Doctors Raphael E. Remondelli, Eugene J. Tyrrell, John P. Coughlin, John B. Fuhrmann, and the chairman. Approximately 15 members and delegates were in attendance. In addition, the President, Dr. Calvin; President-Elect, Dr. Bedrick; Dr. Donnelly and Dr. Satulsky of the Board of Trustees; and the Executive Director, Mr. Nevin, were present.

1. **President** (page 245)

The report of the President was carefully reviewed. The committee took special note of the increasing amount of time and work that the Presidency requires, and wishes to express gratitude to the President for the work he has done during his term of office.

The committee *recommends* approval of the President's report.

Adopted

2. **Board of Trustees—Items** (page 246)

The committee wishes to inform the delegates that copies of the official minutes of The Medical Society of New Jersey Board of Trustees are sent promptly to the Executive Secretary, Secretary, and President of each component society. The introductory section of this report concerning the general activities of the Board of Trustees was reviewed and approved.

The committee *recommends* approval of this portion of the report.

Adopted

A. **Conference of Presidents** (246)

The presidents of the component societies have met with the Board of Trustees twice since the last annual meeting of MSNJ. The first conference and joint meeting were held on October 18, 1964 with 15 societies represented; the second was held on March 21 with 12 societies represented. These meetings were felt to be profitable and illuminating. The presidents have recommended that two meetings a year be continued—one in the fall and one in the spring—and that the president and president-elect of each component society be invited to attend.

The committee feels that such meetings are invaluable in maintaining communications between the Board of Trustees and the component societies.

The committee *recommends* approval of this portion of the report.

Adopted

B. **Inter-Relations with the Judiciary and the Bar** (page 247)

The proposed Professional Liability Panel was discussed in detail. A draft entitled "Statement of Purpose and Intent" was reviewed. Mr. Britton of the American Mutual Liability Insurance Company was present and was asked to comment on several aspects of this proposal.

The committee *recommends* that this matter be referred back to the Board of Trustees and appropriate committees for further study and for the purpose of being put in a final completed form; and further, that this matter

then be brought again before the House of Delegates for consideration.

The committee notes that this matter has been considered for approximately five years, and hopes that it can be put in final form by May 1966. However, should it become necessary to act before the next annual meeting, the committee *recommends* that a special session of the House of Delegates be called to consider this. It is suggested that those delegates who feel that they have worthwhile suggestions should make these known in writing to the Board of Trustees and/or the committees working on this matter.

The committee *recommends* approval of this portion of the report.

Adopted

C. **Special Committees** (page 249)

The reference committee reviewed this report, which is a resume of the work of a special committee "to study the special committee structure of the Society with the thought of streamlining the number of Committees when their function seems to have lost substance."

The reference committee *recommends* that the special committee be continued.

Adopted

The committee *recommends* approval of this portion of the report.

Adopted

3. **Secretary** (page 258)

The report of the Secretary was reviewed. It was noted that due to increased enrollment in the AMA, MSNJ has now achieved its seventh AMA Delegate.

The publishing of the new *Membership Directory* was noted, and the committee wishes to commend the Secretary for the efficient way he has carried out the duties of his office.

The committee *recommends* approval of this portion of the report.

Adopted

4. **Judicial Council** (page 263)

The committee reviewed and discussed thoroughly the report of the Judicial Council. The importance of the Judicial Council cannot be overestimated, and this committee wishes to commend the chairman and the entire Council for the work it has done. It is to be noted with satisfaction that this year the Judicial Council reported the least number of complaints since 1950.

Adopted

5. **Executive Director** (page 268)

The report of the Executive Director was reviewed. It was noted that our Executive Director attended 169 meetings and conferences during the past year, 8 of these being out of the State. In keeping with the increasing gravity and complexity of the problems facing organized medicine, his duties and problems have increased tremendously in recent years. The committee wishes to thank Mr. Nevin for the help and guidance given to the officers and executive secretaries of component societies when they have needed aid with difficult problems, and for the continued excellence in carrying out the duties of his office.

The committee *recommends* approval of this portion of the report.

Adopted

6. **Credentials** (page 272)

This report was reviewed. The committee *recommends* approval of this report.

Adopted

7. **Resolution #1 — Public Relations Personnel** from Essex County (page 325)

There was considerable opposition to this resolution as presented. However, as the discussion progressed, it became clear that the

sponsor of Resolution #1, those in attendance at the reference committee, and the members of Reference Committee "A" were in general accord as to the need for additional help in the area of public relations. Dr. Fullilove pointed out that it was not the intent of the resolution to belittle or disparage the work done by the Executive Director and his staff.

The following points were emphasized in the discussion:

(1) The hiring of a public relations firm at state level would be expensive and would certainly result in an increase in the dues, and there is grave doubt whether the results would justify the expense to be incurred.

(2) Most public relations problems are local in nature and require action at local level.

(3) The office of the Executive Director and the Council on Public Relations have functioned effectively in the past, and at present our public relations at the state level compare favorably with those of states who have hired public relations counsels.

The committee does not recommend approval of Resolution #1 as presented, but does *recommend* approval of the principle involved.

Adopted

It further *recommends* that the Board of Trustees give serious consideration to supplying additional staff members to the Executive Director to help particularly with the problems ecountered with regard to the workings of the Judicial Council, the Council on Legislation, and the Council on Public Relations.

Adopted

The committee further *recommends* that component societies be encouraged to make arrangements at the county level to improve their public relations efforts, each county to act according to its own needs and to determine if such improvements can be made with its own personnel and members, or whether formal public relations help is required.

Adopted

The committee *recommends* approval of this report.

Adopted

8. **Resolution #2 — Society for the Relief of Widows and Orphans of Medical Men of New Jersey** from Essex County (page 326)

This resolution was read, studied, and heartily approved. The committee *recommends* approval of the resolution as presented.

Adopted

9. **Resolution #15 — State Medical Library** from Mercer County (page 334)

This resolution was read and discussed by Dr. Raymond Miller. The reference committee does not recommend approval of the resolution as presented. However, the committee wishes to point out that it is not opposed to the establishment of a medical library. The committee feels that if such a library is to be set up by the State of New Jersey, Rutgers University at New Brunswick should be considered as a possible site.

The committee *recommends* that the resolution be disapproved.

Tabled

Report as a whole adopted as amended

Reference Committee "B"

Nicholas E. Marchione, M.D., Chairman

Reference Committee "B" met on May 16, 1965, with all members present: Doctors Earl L. Warren, David Eckstein, Henry O. vonDeilen, John P. O'Connor, and the chairman. Approximately 15 delegates and members, together with several officers and Trustees, were present to discuss the various items under consideration.

1. **Treasurer** (page 259)

The committee reviewed the detailed report. Several items engendered lively discussion. With the aid and counsel of the Treasurer, Dr. Featherston, we were able to clear up the points of discussion. Along these lines the committee notes, with the approval of the Treasurer, that any member of MSNJ who so desires may request copies of the Treasurer's report in advance of the annual meeting, and may have available to them more details and itemized accounts upon written request to the Board of Trustees.

The reference committee, as in previous years, was impressed with the thoroughness and detail of the Treasurer's report and commends our Treasurer and his staff for a job well done. We *recommend* that the report of the Treasurer be approved as presented, together with our comments.

Adopted

2. **Finance and Budget** (page 272)

Dr. Ware's report was most precise, detailed, and illuminating. Dr. Ware assured us that his committee also will forward a copy of its report to any qualified member of this Society who requests it. To facilitate the work of the House the report will be dealt with by section:

A. **The Journal** (page 272)

We *recommend* that this section of the report be approved as presented.

Adopted

B. **Special Per Capita Assessment** (page 272)

We *recommend* that the House of Delegates vote a special per capita assessment of $5.00 to serve as a contribution to the Medical Student Loan Fund, to be available for loans in 1965-66 (50%); to the bicentennial fund (25%); and to the Library of the Academy of Medicine of New Jersey (25%); and that this assessment not be a part of the budgetary assessment, but that it be billed at the same time.

Adopted

C. **1966 Assessment** (page 273)

Awed but not overcome by the complexity of figures presented, we *recommend* approval of this portion of the report, namely: "That the 1966 assessment remain at $40 per capita, with no provision for a contribution to AMA-ERF."

Adopted

D. **1965-66 Budget** (page 273)

The committee found this report to be sound and accurate and quite well presented. We *recommend* that the budget for 1965-66 be adopted in the total sum of $253,623.00.

Adopted

We *recommend* that the report of the Finance and Budget Committee be approved as presented.

Adopted

3. **Publication** (page 279)

The reference committee was impressed with the zeal and effort of the Publication Committee in its efforts to reduce operating expenses and still publish a better and more informative *Journal*. We commend Dr. Sharbaugh, Dr. Davidson, Miss Goeke, and the Publication Committee for presenting a pleas-

ing, educational, and readable publication.

We *recommend* approval of the report of the Publication Committee.

Adopted

4. **Medical Student Loan Fund** (page 277)

The reference committee *recommends* approval of this report on the activities of the Society's Medical Student Loan Fund and extends its personal thanks to Dr. Mulligan and his committee for their efforts in behalf of furthering medical education by making the economic stress and strain more endurable to medical students.

Adopted

5. **Fiscal and Administrative Years** — referred from the Board of Trustees (page 249)

This item was self-explanatory and lucid. A correction was noted and made—5th paragraph, line 6: "9-month period" changed to "10-month period." The reference committee agrees with the conclusions of the Board of Trustees and *recommends* approval of this item as printed.

Adopted

6. **Resolution #10 — The Academy of Medicine of New Jersey** from the Board of Trustees (page 331)

The reference committee well recognizes the value and need for maintaining a medical library in the State of New Jersey and is most sympathetic to the request of The Academy of Medicine of New Jersey. However, in view of our recommendation to adopt the report of the Committee on Finance and Budget with an allocation of funds from a special per capita assessment, we are compelled to *recommend* that this resolution be not approved at this time.

We suggest that any surplus monies from the Bicentennial Fund be turned over to the Library of the Academy of Medicine, and that their request be reconsidered next year when bicentennial funds may no longer be required.

Adopted

7. **Resolution #3 — Allocation of Funds for New Jersey Medical Schools** from Bergen County (page 327)

This resolution was thoroughly discussed by all present. Following discussion, the spokesman for the resolution, Dr. Heller, withdrew the paragraph 3. This in no way alters the intent or purpose of the resolution.

The reference committee notes that resolution #3, while commendable in its purpose and intent to further aid medical education, is not specific and makes no provision for the utilization of the funds to be collected, namely: whether the funds are to be distributed unrestricted either for building purposes or research, or for specific areas of medical education. Therefore, we *recommend* that resolution #3 be not approved.

Adopted

The chairman at this time wishes to thank the members of his reference committee, the Officers and Trustees who provided advice and counsel, and all other members and delegates who participated in the meeting.

Report adopted as a whole

Reference Committee "C"

F. Clyde Bowers, M.D., Chairman

Reference Committee "C" met on Sunday, May 16, 1965, with the full complement of members present: Doctors Edwin H. Albano, John M. Naame, Rudolph T. DePersia, Francis A. Pflum, and the chairman. Approximately 40 members of The Medical Society of New Jersey were present to discuss the various items under consideration.

1. **Medical Service Administration** (page 313)

The committee *recommends* approval of this report.

Adopted

2. **Medical-Surgical Plan** (page 315)

The committee *recommends* approval of this report.

Adopted

3. **Medicare Program** (pages 313)

The committee *recommends* approval of this report.

Adopted

4. **Board of Trustees — Items**

A. **Approval for Individual Diagnosis** (page 250)

The committee *recommends* approval of this item.

Adopted

B. **Group Health Insurance of New Jersey** (page 251)

The committee *recommends* approval of the action of the Board of Trustees as reported.

Adopted

C. **Nominations for Board of Governors, MSA** (page 252)

The committee approves the nominations to the Board of Governors of Medical Service Administration as presented and *recommends* their approval by the House.

Adopted

D. **Nominations for Board of Trustees, MSP** (page 251)

The committee approves the nominations to the Board of Trustees of Medical-Surgical Plan and *recommends* their approval by the House.

Adopted

5. **Resolution #4 — MSP Contract Inequities** from Middlesex County (page 327)

The reference committee approves of this resolution from Middlesex County except for the third "resolved" which the committee *recommends* be deleted. The committee feels that the present allocation of fees by MSP are considered proper and sees no need for this "resolved" paragraph.

The reference committee *recommends* approval of this resolution as amended.

Adopted

6. **Resolution #11 — Approval by Individual Diagnosis** from a Delegate and a Member of Hudson County (page 331)

The reference committee disapproved this resolution and *recommended* that the House also disapprove it.

Adopted

7. **Resolution #12 — Blue Cross-Component Society Liaison Committee** from a Delegate and a Member of Hudson County (page 332)

The committee *recommends* disapproval of this resolution.

Adopted

8. **Resolution #20 — Approval by Individual Diagnosis** from Middlesex County (page 337)

The reference committee *recommends* disapproval of this resolution, which action is consistent with the recommendations already made. However, the committee recognizes some constructive suggestions in this resolution and would like to *recommend* within its discretion an alternate version embracing the views of the reference committee:

Whereas, the members of The Medical Society of New Jersey are vitally concerned with aiding the control of hospital and medical costs by preventing unnecessary lengths of hospital stay; therefore be it

RESOLVED, that additional measures be promoted by the Blue Cross-Blue Shield plans to conserve hospital costs, along the following lines: payment by Blue Shield for office procedures in all contracts, thus avoiding large Blue Cross costs; development of a new formula of payments to hospitals by Blue Cross to encourage economy of operations; removal of the present discounting of hospital bills in compensation cases; cooperative efforts with local, county, and state legislative bodies to pay full costs of indigent patients from general tax funds, thus decreasing the costs to insured patients; and encouragement of, and cooperation with, hospitals to place them on a seven day a week basis.

Adopted

Report adopted as a whole

Reference Committee "D"

Ralph M. L. Buchanan, M.D., Chairman

Reference Committee "D" met at 11:00 a.m., Sunday, May 16, 1965, with all members present: Doctors John F. Johnson, John J. Torppey, Thomas H. McGlade, Charles S. McKinley, and the chairman. Approximately 20 members and delegates were present.

1. **Medical Defense and Insurance** (page 275)

This report reflects the activities on major medical expense insurance, accident and health insurance, high-limit accident insurance, life insurance, and professional liability insurance. During the meeting, the chairman of the insurance committee, Dr. Featherston, announced that the number of defendant verdicts has increased from 14 to 21 since publication of his report.

The committee *recommends* the approval of this report, including its two recommendations:

(1) That the American Mutual Liability Insurance Company be continued as the officially designated carrier for our professional liability insurance program.

(2) That the E. & W. Blanksteen Agency be continued as the official broker for our accident and health, high-limit accident, major medical, and life insurance programs.

Adopted

2. **Medical Education** (page 277)

This report from Dr. Garrison's committee contains no recommendations.

The reference committee *recommends* that the report be accepted with thanks.

Adopted

3. **Medicine and Religion** (page 306)

The report of Dr. Kaufman's committee contains no recommendations.

The committee *recommends* that it be accepted with thanks.

Adopted

4. **Retirement Plan for Physicians** (page 308)

The report of Dr. Marchione's committee was considered. The committee *recommends* approval of the report and its recommendation:

Despite the relative quiet with relation to Retirement Plans this year, we still recommend the continuation of the Special Committee on Retirement Plan for Physicians as a clearinghouse for information and study of any future changes and thinking on retirement plans for physicians.

Adopted

5. **Board of Trustees — Items**

A. **General Practice** (page 252)

The reference committee discussed this item and places particular emphasis on the following from this item:

The importance of each county medical society's having a Future Physician's Club, headed if possible by an enthusiastic G-P, and the still greater importance of every physician's encouraging qualified young men and women to attend medical school cannot be overemphasized.

The committee *recommends* that this item be approved.

Adopted

B. **Medical Schools in New Jersey** (page 253)

In discussion of this item, the committee noted that there was a meeting, by invitation of Dr. Gross, President of Rutgers, which included the Board of Trustees of MSNJ, presidents of component societies, and representatives of the Rutgers University Medical School. As a result of this meeting, it is our impression that the objective of the new medical school will be the development of M.D.'s, and that what they pursue later is entirely up to them.

Last sentence amended to read:

As a result of this meeting, it is our impression that the objective of the new medical school will be the development of practicing physicians.

It is also noted that Seton Hall has been renamed the New Jersey College of Medicine and Dentistry, located in Jersey City.

The reference committe *recommends* approval of this item.

Adopted as amended

Report as a whole adopted as amended

USPHS Child Health Survey

Five New Jersey counties (Warren, Essex, Morris, Hudson, Union) have been selected as part of a nationwide sampling for the study of the health of children. The survey will be conducted by public health service personnel; and if the parents request a report of their findings, it will be sent to the child's physician.

The children are chosen by a scientific sampling, and the survey is for the purpose of collecting uniform statistical data on children's health and on physical and physiologic measurements related to growth and developments. Families will be told that this is not a complete examination and referred back to their own doctors for this purpose.

Reference Committee "E"

Donald T. Akey, M.D., Chairman

Reference Committee "E" met on Sunday, May 16, 1965 in the West Room on the Tower Floor with all members present: Doctors Donald T. Akey, chairman; Edward A. Schauer, Matthew E. Boylan, Robert E. Verdon, and Frank B. Vanderbeek. Approximately 70 members and delegates were present to discuss the various items under consideration:

1. **Board of Trustees — Items**

National Education Program (page 253)

Pre-Employment Physical Examinations (page 255)

Statewide Medical Examiners' System (page 255)

The committee first considered those portions of the report of the Board of Trustees referred to it.

The committee *recommends* approval of all three items listed above.

Adopted

2. **Council on Legislation** (page 283)

The committee reviewed the great volume of bills concerning which the Society has taken an official position. The committee commends Dr. McCall and the Council on Legislation for their generous and excellent work.

The committee *recommends* approval of the reports of the Council on Legislation.

Adopted

3. **Council on Public Relations** (page 303)

The committee reviewed the report of the Council on Public Relations, particularly those portions dealing with emergency coverage and the basic concepts underlying the provision of professional medical care.

The committee commends Dr. Kustrup and his committee for their study and elucidation of the basic concepts. It urges all members of the Society to familiarize themselves with these concepts, and *recommends* unanimously to the House that they be approved.

The committee *recommends* approval of the report in its entirety.

Adopted

4. **Resolution #5—Community Mental Health Centers** (page 328) from Bergen County

The committee has unanimously concluded that, in spite of the promised phasing out of the governmental subsidy to cover operating expenses, the danger is great that the governmental subsidy and control of the institutions involved may be continued indefinitely. Moreover, favorable action on this resolution would be contrary to the AMA's position against governmental subsidy and operational control of the practice of medicine.

For these reasons, the committee *recommends* that the resolution be disapproved.

Not adopted

Resolution #5 approved by House of Delegates

5. **Resolution #7—Reinstatement of Full Tax Deductibility of Medical Expenses of the Elderly** from Bergen County (page 329)

The committee *recommends* approval of this resolution.

Adopted

6. **Resolution #14—Medicare (HR-6675)** from two Essex County Delegates (page 333)

The committee *recommends* approval of this resolution.

Adopted

7. **Resolution #18—Section 6, AMA Principles of Medical Ethics** from an Ocean and a Monmouth County Delegate (page 335)

Resolution #22 — Against Boycotting Medical Care Legislation from an Essex County Delegate (page 338)

These two resolutions were considered together because they make contradictory recommendations concerning the same subject field.

After much discussion and detailed study, the committee unanimously agreed that, since the federal legislation is still being evolved and no specific law has been enacted, both these resolutions are untimely.

The committee, therefore, *recommends* that both these resolutions be not approved.

Adopted

8. **Resolution #21 — Subsidized Voluntary Health Insurance Programs** from a Union County Delegate (page 338)

The committee was of the unanimous opinion that The Medical Society of New Jersey — through its support of the Kerr-Mills Law and the Herlong-Curtis Eldercare Bill—has already clearly and strongly recorded itself as supporting the position that this resolution urges. Accordingly, in the opinion of the committee, this resolution is superfluous and should not be approved.

Your committee so *recommends.*

Adopted

9. **Resolution #25—Compulsory Medical Care Insurance for the Entire Population** from an Essex County Delegate (page 342)

This resolution was studied in detail and at great length. It was the unanimous conviction of your committee—despite the opinion to the contrary of its sponsor—that basically this resolution urges the establishment of a governmentally-controlled compulsory health insurance program and as such is incompatible with the official position of The Medical Society of New Jersey and of the American Medical Association.

The committee *recommends,* therefore, that the resolution be disapproved.

Adopted

Report as a whole adopted as amended

I take this opportunity to thank the members of my committee for their patience and generous effort in carrying out the long deliberations of this reference committee.

Reference Committee "F"

Dorsett L. Spurgeon, M.D., Chairman

Reference Committee "F" met on Sunday, May 16, 1965, with all members present: Doctors J. Bruce Henriksen, Robert G. Stineman, R. Winfield Betts, Adolph R. Wichman, and the chairman. Approximately 18 members attended the meeting with about 75% participation in the discussion.

1. **Medical Services** (page 291) and

Resolution #16 — Rehabilitation Commission Fee Schedule from Mercer County (page 335)

A. The committee *recommends* that the report of the Council on Medical Services be

accepted as a progress report, with the suggestion that further study be given to the Medical-Surgical-Anesthesiology problem toward some satisfactory solution of this difficulty.

Adopted

B. The committee noted that there had been a meeting of the Special Committee on Rehabilitation with representatives of the New Jersey Rehabilitation Commission on April 5, 1965, "in an effort to develop a more realistic fee schedule for the Rehabilitation Commission," and that further conferences are to be arranged. In view of the fact that the subject of the resolution has already been initiated and revision of the fee schedule is already underway, the committee *recommends* that Resolution #16 be not approved.

Adopted

2. **Occupational Health and Workmen's Compensation** (page 292)

This combined report from the chairman of the two committees is *recommended* for acceptance as a progress report.

Adopted

3. **Areawide Planning for Hospitals** (page 255) — referred from the Board of Trustees; and

Resolution #23—Areawide Planning for Medical Facilities (page 339) from an Essex County Delegate

A. The comittee *recommends* that the item on Areawide Planning for Hospitals, as reported by the Board of Trustees, be approved and that the Board be commended for its action in participating in the Health Facilities Planning Council for New Jersey. It is hoped that this Planning Council can be kept a voluntary body.

Adopted

B. With the deletion of one phrase, the committee approved Resolution #23. It *recommends* that the first "resolved" paragraph be amended to read:

RESOLVED, that The Medical Society of New Jersey affirm its continued official support and membership in the Health Facilities Planning Council for New Jersey. (TO BE DELETED: and that it plan to pay on a yearly basis whatever the cost will be for a full participating membership in said organization)

Adopted

4. **Rights of Physicians in Hospitals** (page 256) — referred from the Board of Trustees

The committee *recommends* approval of this item.

Adopted

5. **Resolution #8—Discrimination** from Essex County (page 330)

In connection with this resolution the committee noted that the AMA House of Delegates in June 1964 adopted a resolution on "Human Rights and Discrimination" which our AMA Delegates supported. The committee *recommends* that resolution #8 be approved.

Adopted

The committee suggests that component societies and their members who have resolutions to propose to this House of Delegates refrain from releasing reports on their resolutions to the press before the House has had an opportunity to consider and act upon such resolutions.

Adopted

Report adopted as a whole

Reference Committee "G"

Joseph M. Gannon, M.D., Chairman

Reference Committee "G" met on Sunday, May 16, 1965, with all members present: Doctors John S. Van Mater, Charles L. Cunniff, Benjamin F. Lee, Joseph R. Burns, and the chairman. Fifteen delegates and members were present to discuss the many items.

1. **Public Health** (page 293)

The reported items on Drug Addiction Problems, Sabin Oral Polio Vaccine Immunization, Air Pollution, the Committee on the Chronically Ill and the Aging, the Committee on the Conservation of Vision, and the Committee on Mental Health are *recommended* for approval, including the recommendation (page 293):

"That the Board of Trustees of The Medical Society of New Jersey make the Subcommittee on Air Pollution a special committee under the Council on Public Health."

Adopted

2. **Air Pollution** (page 295)

The report on Air Pollution is *recommended* for approval as written with the addition to item 2, "Accomplishments", of Mercer, Morris, and Camden Counties to the roster of the 15 counties already having established air pollution committtees.

Adopted

3. **Cancer Control** (page 296)

The reference committee *recommends* approval of this report.

Adopted

4. **Child Health** (page 296)

This report is *recommended* for approval.

Adopted

5. **Chronically Ill and the Aging** (page 298)

This report was discussed at length. Paragraph 3, which mentions "Accreditation of Nursing Homes", was approved inasmuch as it appeared to be only mentioned as a principle. Paragraph 4 on "Emphysema" was approved. Paragraph 5 concerned itself with the increasing number of "Cardiac Surgical Centers" within the State and the possible duplication of facilities therewith. The reference committee approved the action "That the Society's representatives on the Health Facilities Planning Council for New Jersey encourage centralization and more effective cooperative utilization of cardiovascular surgical centers throughout the State," inasmuch as this appeared merely to "encourage" and not to coerce.

The paragraph on page 299 relating to the "Responsible Relatives Provision" of the MAA Program in New Jersey was discussed at great length. The reference committee approved the reported action that this responsible relatives provision of the law be abolished. The reference committee felt that while a child should feel morally responsible for the debt of his parent, there should be no legal responsibility in this regard. Further, the reference committee felt that *all* "Responsible Relatives Provisions" of the law should be abolished. The reported action that annual certification to provide eligibility in advance of need for actual care was looked upon favorably by the reference committee. The summary of actions regarding changes in the New Jersey MAA Program (page 299) were approved with the exception of item 2. "Liberalization of income standards to make more aged eligible." The reference committee *recommends* that this be amended to read, "2. Continuing review of income and liquid assets standards to make the MAA Program as equitable as possible."

Adopted

We *recommend* that the report on Chronically Ill and the Aging be approved as amended.

Adopted

6. **Conservation of Hearing and Speech** (page 300), **Conservation of Vision** (page 300), and **Maternal and Infant Welfare** (page 301)

The reports on Conservation of Hearing and Speech, Conservation of Vision, and Maternal and Infant Welfare are all *recommended* for approval.

Adopted

7. **Mental Halth** (page 301)

The report on Mental Health is *recommended* for approval.

Adopted

Attention is invited to item 3 which cites the Mental Health Act of 1965 (A-128); this has now become proposed amendment to Title 30 (A-480) and as such has already passed the Assembly and is in the Senate.

Received as information

8. **Rehabilitation** (page 302)

The report is *recommended* for approval.

Adopted

9. **Items from the Board of Trustees**

The reports on **Cigarette Smoking** (page 256) and **Drug Addiction Problems** (page 257) are *recommended* for approval as submitted.

Adopted

10. **Resolution #9 — Recognition of Alcoholism as a Disease** from Bergen County (page 330) is *recommended* for approval as submitted.

Adopted

11. **Resolution #13—Routine "Pap" Test** from Camden County (page 333) is *recommended* for approval as submitted.

Adopted

12. **Resolution #24 — President's Commission on Heart Disease** from an Essex County Delegate (page 340) was discussed at great length. In the interest of clarity, it was felt that this resolution should be rewritten and condensed as follows:

Whereas, the President's Commission on Heart Disease, Cancer, and Stroke has recommended a program to establish throughout the United States diagnostic and treatment centers for these specific diseases; and

Whereas, the effecting of this program would radically change the private practice of medicine in these fields; and

Whereas, this program would establish a deadening centralization of the practice in the areas of heart disease, cancer, and stroke; therefore be it

RESOLVED, that even though The Medical Society of New Jersey recognizes the praiseworthiness of the endeavors of the President's Commission on Heart Disease, Cancer, and Stroke to further medical knowledge and improve treatment of these crippling diseases, it nevertheless is troubled by the vague outlines of the Commission in its approach to this problem, feeling that implementation of them would bring a disastrous lessening of good medical care which is now available in our hospitals; and be it further

RESOLVED, that The Medical Society of New Jersey approves the recent AMA Staff Report, A National Program to Conquer Heart Disease, Cancer and Stroke, JAMA; 192: 299-301, April 26, 1965, and supports the AMA in its position on this matter.

We *recommend* approval of this substitute resolution.

Adopted

The chairman wishes to thank all the members of the reference committee and all the members who joined in the discussion.

Report adopted as a whole

Reference Committee "H"

Andrew C. Ruoff, III, M.D., Chairman

Reference Committee "H" met on Sunday, May 16, 1965, with all members present: Doctors Edward M. Coe, Edward A. Jasionowski, Charles Cunningham, Josiah C. McCracken, Jr., and the chairman. Eight delegates were present and participated in the discussion.

1. **Annual Meeting** (page 269)

The report of this committee was reviewed, and approval of this report is *recommended* including the committee's recommendation:

That the 203rd annual meeting be held at Haddon Hall, Atlantic City, Saturday-Wednesday, May 17-21, 1969.

Adopted

2. **Scientific Exhibits** (page 270)

The committee *recommends* approval of this report as printed.

Adopted

3. **Scientific Program** (page 271)

The committee *recommends* approval of this report as printed.

Adopted

4. **Disaster Medical Care** (page 306)

The reference committee compliments this committee on its activity and *recommends* approval of this report as printed.

Adopted

5. **Honorary Membership** (page 274)

The committee *recommends* approval of this report as printed.

Adopted

6. **Nursing Education and Recruitment** (page 307)

The committee *recommends* approval of this report as printed.

Adopted

7. **Traffic Safety** (page 309)

There was some discussion of this report, with one delegate recommending that future activity of this committee include strong recommendations for improvement in safety devices in automobiles.

The committee *recommends* that this report be approved as printed, including the following recommendations:

(1) That The Medical Society of New Jersey urge the installation of seat belts in both front and rear seats of all passenger vehicles.

(2) That the Board of Trustees urge all members of the Society to install and use front and rear seat belts in their cars and to be at pains regularly to use such seat belts as an example to the members of the public.

(3) That the Society invite the Bar Association, Nurses' Association, Congress of Parents and Teachers, and members of the Woman's Auxiliary to cooperate in carrying out these recommendations.

(4) That The Medical Society of New Jersey request the State Department of Purchase to require adequate safety facilities in vehicles purchased by the State for official use, in compliance with standards and specifications being developed by the General Services Administration, purchasing agency for the Federal government.

Adopted

8. **Woman's Auxiliary Advisory** (page 282)

Doctor Rowohlt, chairman of the advisory committee, was present and announced that the Sussex County Medical Society had not yet approved the formation of an auxiliary in that county. He requested that the fourth paragraph of his report, as printed, be amended to read:

As well as increasing its over-all membership, the State Auxiliary has been happy officially to welcome the Morris County Medical Society's Auxiliary into the State organization. This year we are happy to report that the Sussex County Medical Society *is contemplating* its approval for the formation of the twenty-first and last county auxiliary in our State *and has scheduled final decision on this at its June meeting.*

With this amendment of the fourth paragraph, the committee *recommends* approval of this report.

Adopted

9. **Nominations for Emeritus Membership** (page 310)

Including those on the supplemental report, the nominations were reviewed and the reference committee *recommends* approval of all nominations.

Adopted

In the course of discussion on emeritus membership, it was brought up by the committee and from the floor that there is definite possibility that an emeritus member might want to return to practice at some date in the future, or that an emeritus member might decide to practice in another state at some date in the future. It is unclear as to how this situation would be met, and the committee *recommends* that the Committee on Revision of Constitution and Bylaws review the possibilities of these eventualities and possibly present an amendment in the future.

Adopted

10. **Board of Trustees – Items**

A. **AMA Membership Opinion Poll** (page 257)

This item was for information only in order to inform the House of Delegates as to the failure of the House of the American Medical Association to adopt our Resolution #8 from the 1964 House of Delegates.

Received as information

B. **Bicentennial Celebration** (page 257)

This item is *recommended* for approval as printed.

Adopted

C. **Woman's Auxiliary Membership** (page 257)

There was spirited discussion on this item, and it was the consensus of all present that full auxiliary enrollment would certainly be laudable but that no element of compulsion should be entertained.

The committee *recommends* approval of the Board of Trustees' position as printed.

Adopted

11. **Resolution #17—Auto Drivers' Licenses** from a Passaic County Delegate (page 335)

The committee *recommends* approval of this resolution as presented:

RESOLVED, that The Medical Society of New Jersey endorse the recommendation of the New Jersey Committee on Trauma of the American College of Surgeons and strongly recommend that the State of New Jersey follow the example of the State of North Carolina and revise its drivers' licenses to include space for immunization information and other medical identifying data on the reverse side of the automobile drivers' licenses.

Adopted

Report adopted as a whole

Reference Committee on Constitution and Bylaws

Luke A. Mulligan, M.D., Chairman

The Reference Committee on Constitution and Bylaws met on Sunday, May 16, 1965, with all members present: Doctors Henry J. Konzelmann, Clement M. Jones, Frank M. Galioto, C. Spencer Davison, and the chairman.

1. **Committee on Revision of Constitution and Bylaws** (page 281)

The report of the Committe on Revision of Constitution and Bylaws was unanimously accepted.

The proposed amendments to the *Bylaws, Chapter VII, Section 7,* as approved by the Committee on Revision of Constitution and Bylaws, were approved by the reference committee:

Amend second paragraph of Section 7 to read:

> Decision of the said Judicial Council in any matter so appealed shall be final, except that further appeal may be taken by a principal who is a member of the American Medical Association, to the Judicial Council of the American Medical Association, if the subject of the dispute falls within the jurisdiction of that Council.

Insert the following paragraph between the current fourth and fifth paragraphs:

> Any appeal to the Judicial Council of the American Medical Association must be filed within thirty (30) days of the date of the decision of the Judicial Council of The Medical Society of New Jersey, and the appeal shall be perfected within sixty (60) days thereof, although for good and sufficient cause an additional thirty (30) days may be granted for perfecting the appeal.

The reference committee *recommends* the adoption of the report of the Committee on Revision of Constitution and Bylaws; and further *recommends* the adoption of these proposed amendments to Chapter VII, Section 7, of the Bylaws.

Adopted

2. **Resolution #19 — County Judicial Committees** from a Bergen County Delegate (page 336)

In keeping with the first and second paragraphs of Chaper XII, Amendments to the Bylaws, the reference committee *recommends* that Resolution #19 pertaining to County Judicial Committees be referred to the Standing Committee on Revision of Constitution and Bylaws for study and report at the 1966 annual meeting.

Adopted

Report adopted as a whole

GENERAL SESSION

Sunday Afternoon, May 16, 1965

The General Session convened at 3:00 p.m. President Calvin presided. James Z. Appel, M.D., President-Elect of the American Medical Association, was guest speaker. The title of his speech was *Who Really Wants Medicake?*

President Calvin: I now declare the General Session in order.

I have a happy duty to perform. To introduce our distinguished speaker, I have invited our illustrious member, Dr. David B. Allman, Past-president of the American Medical Association.

Dr. Allman, will you please come to the podium? I don't have to introduce Dave. You know him as well as I.

(Applause)

Dr. David B. Allman: Mr. President, Officers, Members of the House of Delegates, Friends:

Next month it will be eight years ago that I received the highest honor in my life, at which time with the help of many of you in the room I was elected President-elect of the American Medical Association. I haven't received very many honors since that time, but I did yesterday when I walked into this hotel, when our President, Dr. Calvin, said that I had been selected to present to you the speaker for this afternoon's session. I felt greatly honored for several reasons. One is, the gentleman I'm about to introduce is a very good personal friend of mine. The second reason I felt honored was because he is a very good friend of New Jersey. He comes from Lancaster, Pennsylvania, but at all times next to his home state of Pennsylvania he has been battling for New Jersey; and I can assure you that you are going to hear not only from the next man who will become President of the AMA next month, but you are also going to hear from a great friend of ours.

I could speak a long time about Dr. Appel and his accomplishments. He comes from a long line of distinguished physicians. He is a true disciple of Aesculapius. He practices medicine as it should be practiced. We of the American Medical Association will be deeply proud of the high honor that he is going to reflect on us during his tenure of office.

I'm not going to gild the lily. Most of you know Dr. Appel personally. If you don't, you will hear much more about him in the next thirteen months. I could go on and take a lot of his time by telling you all of his accomplishments and all of his efforts in behalf of medicine. I'm not going to do that for several reasons, the main one being that when they introduce the President of the United States they simply say: "Ladies and Gentlemen, the President of the United States."

I think that James Z. Appel is entitled to about that same consideration. So, Mr. President, I'd like to introduce the President-elect of the American Medical Association.

(Standing ovation)

Dr. James Z. Appel: Thank you very much, Dave.

Dr. Calvin, Members of the House of Delegates of the New Jersey Medical Society, and Ladies and Gentlemen:

I think your program said I was going to talk about the future of organized medicine. Well, when I was invited to come down here to speak, I thought that's what I was going to talk about. However, certain things have developed that I'm going to beg the privilege of changing my talk, and talk about something else.

It's been a good many years since I had the privilege of attending a meeting of The Medical Society of New Jersey. I came down here when I was on the Board of Trustees of my own State Society with one of my staff men. We were investigating the possibility of holding our state society meeting in New Jersey. Up to that time, we always held them in Pennsylvania. After our investigation, we did

hold them here. I don't think they will be held here in the future very much, because of some changes in Pennsylvania.

But I do want to take this opportunity to express my appreciation to Mrs. Madden, because she did a very excellent piece of hospitality when Mr. Stewart and I were here at that particular time and made it so much easier for Pennsylvania to change the site of its annual sessions from either Pittsburgh or Philadelphia to Atlantic City. So I can't forego this opportunity to thank her for what she did for us.

As I said, I was going to change my talk. My particular subject is "Who Really Wants Medicake?" This is a little personal whim of mine. The definition of Medicare has been changed so often that, to me, it doesn't mean much any more. You know, the first was for the federal employees or dependents of the military services. That was Medicare. Then it got to be a hospitalization program, and now it's something else which the authors have called a cake. So I like to refer to this as Medicake, because that's what I think it is, and I think you will understand why.

"The Americans are still of the opinion that more is to be got for human happiness by private energy than by public legislation."

That statement was written by Sir Henry Maine in his book, *Popular Government,* back in 1885 . . . some 80 years ago.

In 1965 how many Americans would have such an opinion? How many Americans really care about private enterprise? How many care about a free society? How many care about their freedom of choice?

Recently at the New York World's Fair, the Daily News Public Opinion Poll showed that visitors rejected the welfare state by better than 3 to 2, saying that it destroys individual initiative.

Perhaps this anti-welfare state vote should be somewhat encouraging to the proponents of a free society. But in the same poll the question was asked: "Should retirement under Social Security be lowered to age 60?"

This time the vote was almost 3 to 2 in favor of lowering the age.

Amazing? I think it is. For people to reject the welfare state on the one hand because it destroys individual initiative and on the other hand to accept a federal system of regressive, or consumer, taxation to assist everyone over 60, rich and poor alike, is truly amazing.

It is even more amazing to me that too many Americans are *not* really worried about the federalization of their lives, their activities, their comings and goings. As long as the federalization is done in the name of a higher and better life — the Great Society . . . too many Americans consider the direct or indirect controls over their lives by the federal government as necessary or at the worst tolerable.

Today too many Americans are content to let Washington run things. We either don't trust ourselves or we leave the decisions to our leaders in Washington.

Everything from sex education to housing is a national problem; and of course, it requires a national solution. Even though our nation has always operated on the basis of competitive principles, too many Americans are ready and willing to be restricted . . . a little here and a little there . . . in the interest of the *national* solution to the *national* problem in order to reach the *national* goal.

Remember when fellows like Norman Thomas and Dr. Townsend wanted the working man to have a greater share of the pie? Of course, much of this was "pie-in-the-sky" but it did have some appeal.

But today those who know what is best for the rest of us are not offering pie; they present us with cake . . . a multi-layered cake with plenty of frosting.

The cake, of course, is for everyone . . . young and old, rich and poor, taxpayer or retired. How can it be ours? Not through private en-

ergy, of course, but through public legislation.

So the legislation diminishes freedom rather than enlarging it. So the legislation is restrictive and opposed to our traditions of freedom. What difference does it all make as long as there is some cake for all and as long as our leaders promise us that the legislation will lead us all to a better life?

The latest cake that has been concocted for us is, of course, the "Medicake" . . . a multi-layered item heavily frosted to please as many elements of the public as possible. Well hidden between other layers of the cake, and surrounded by the frosting, is the oft-rejected proposal called "medicare," a bill that never could get anywhere standing alone.

Those who have concocted this layer cake are hoping, perhaps, that the "medicare" layer of cake will remain in its entirety because no one would want to destroy the rest of the cake.

They were so fearful that Medicare would not stand public scrutiny that the House Ways and Means Committee did not allow public hearings on the concoction. Then in the U. S. House of Representatives only one amendment to recommit was allowed, and after that was defeated there was only limited debate permitted.

So the six-billion-dollar cake is still in one piece. To its proponents the concoction is an angle cake; to its opponents it is a devil's cake; to taxpayers it will be a real "pound" cake; and in the Senate Finance Committee I am hoping it will be a "hot" cake.

You may not have ever taken the time to look up the definition of the word "cake," but the other day I did. I was intrigued with the definition I found.

"Cake: a small mass of dough, sometimes unleavened, baked on both sides, or

"A sweetened composition of flour and other ingredients, leavened or unleavened, baked in a loaf or mass of any size or shape."

Well, after reading the Administration bill I am convinced that the cake is indeed a "mass of dough." But it is not so small, and the "mass of dough" will come from the taxpayers in the form of higher Social Security payments and higher prices on products they use.

And, indeed, the "Medicake" is a sweetened composition baked in a mass of any size or shape. It is sweetened with such items as a cash benefit increase of Social Security recipients. It comes in a mass of great size—296 pages—and in any shape—including anything and everything from withholdings on the tips of waiters to the old, rejected King-Anderson bill.

Despite the proposal's mass, shape, and size, the Administration wants to get this expensive cake baked in a hurry.

Congress has been asked—some might say "ordered"—by the President to vote on the proposal as quickly as possible. The House dutifully did just that. The emphasis seems to be: "Rush the bill through Congress. Let's hurry this thing through before the people have time to understand what it is all about."

But the measure *is* too complicated to rush! Its impact on the nation's economy and the future of the nation's health care system *would be* incredible. The cost of its financing *would be* staggering. The extent of its controls on hospitals, nursing homes, physicians and the nation's health team *would be* great indeed.

Why then all this haste to pass this "three-layer-cake" bill, the most far-reaching omnibus welfare bill in 30 years?

Here is a bill to add a compulsory hospitalization measure to the Social Security system, a system which heretofore gave beneficiaries *dollars* not benefits.

Here is a bill authorizing a federally-subsidized system of health insurance to cover

medical and surgical and drug bills.

Here is a bill to expand the present Kerr-Mills law to cover dependent children and blind and disabled persons.

Here is a bill to include self-employed physicians under Social Security.

Here is a bill to increase Social Security cash benefits, give benefits for widows at age 60, amend the disability program, liberalize the earned income limitation in the retirement test, cover cash tips as wages, exempt the Amish and certain other religious sects from Social Security taxes and coverage, and many other items.

Many of these goals are fine in themselves. But let's take time to think about doing them correctly!

Besides all this, this bill would raise the wage base for the Social Security tax on the employee and employer to $5,600 annually instead of the present $4,800. But this higher wage base would be in effect for only four years. Then, the wage base for tax purposes would jump still higher to $6,600.

Here is a bill that also would raise the Social Security tax rate from its present 3⅝ per cent to 4.35 per cent in 1966. Not only that, but this bill outlines a series of tax rate increases through the year 1987. By then the tax rate would be 5.6 per cent or almost two full percentage points more than it is now.

So this bill will raise the annual Social Security taxes of wage-earners and employers from the present maximum of $174 each to $243.60 in 1966, or an increase of $69.60.

It will raise these same taxes to $369.60 on the employee and $369.60 on the employer by 1987.

Finally, here is a bill designed to cost an estimated 6.6 billion dollars in its first year of operation.

It is truly regrettable that the House Ways and Means Committee did not hold public hearings so that all the provisions of this measure could be thoughtfully examined by all who support it and by all who oppose it.

Is the American public to believe that its best interests will be served by the headlong rush to ram this legislation through Congress?

It is regrettable that the Committee gave no consideration to the Herlong-Curtis Eldercare bill, a proposal which offers a sound and sensible solution to the problem of helping the elderly who *need* help in financing their medical expenses.

The Eldercare bill gained more public support in the shortest period of time than any legislation on the health care for the elderly ever introduced in Congress.

Another independent poll in Colorado brought almost identical results.

A recently completed nationwide public opinion survey conducted by the Opinion Research Corporation of Princeton, New Jersey, showed that 74 per cent of the nation's adults favor the Eldercare proposal and only 14 per cent favor the Medicare-tax plan. Only 12 per cent of those polled had no opinion.

The volume of mail, the vast majority of it in support of Eldercare, was enormous. The postmaster of the House of Representatives reported that in his long years of service in the post, no legislation had ever generated as great a flood of mail as Eldercare. At the height of the campaign, the AMA received more than 1,000 letters a day, only a fraction of one per cent of them opposed to our stand. As a result of state and county society programs, many of these also received a flood of mail on Eldercare.

The mail response alone, in my opinion, reflected the effectiveness of the educational programs conducted by the AMA, the state societies, individual physicians, and the friends and allies of medicine.

Virtually every state society and many county societies developed and carried out their own educational programs in conjunction with the

AMA campaign, using newspaper advertising, radio and television spots, pamphlets and speakers, counter cards, and even billboards in some states.

The AMA produced two pamphlets and reprinted an article from Readers Digest. Request for pamphlets totaled more than 22 million, the greatest number by far in an AMA campaign. One pamphlet was translated into Spanish and Cantonese. In addition, some 10,000 packets of materials were distributed for debate and discussion groups.

The AMA ran advertisements in three national newspapers, 12 national magazines and 12 regional magazines. Spots were placed on the Mutual radio network (470 stations) and the ABC network (252 stations) and on 19 clear-channel stations. Fifteen 60-second spots ran on 180 ABC-TV network stations. Spots also were placed on 166 independent television stations. A half-hour film was carried on 50 television stations.

At AMA suggestion, four phases of Operation Hometown were reactivated.

Although the prospect is unlikely, should some future historian decide to chronicle the the events of this educational program, he would, no doubt, be astonished at the spontaneous grass-roots response to the Eldercare program.

He would record:

1. Scores of radio and television programs all over the nation were developed to explain the issues.

2. Eldercare articles and feature stories on Eldercare versus Medicare appeared in daily and weekly newspapers. Some papers reproduced the AMA Eldercare Question and Answer pamphlet in full. Hundreds of editorials, most supporting Eldercare, were published in all sections of the country.

3. Citizens for Eldercare groups, some headed by people over 65, popped up from coast to coast. These groups, as well as women's clubs, farm organizations, and civic clubs organized a wide variety of projects to promote Eldercare, including debates, town hall style meetings, fireside chats, and the like.

4. Broad-scale support for Eldercare came from business and industry. More than 400 major industrial firms, for example, requested pamphlets from AMA for distribution to their employees.

Meanwhile, the AMA Washington staff was in constant contact with the members of Congress, explaining the principles of Eldercare and soliciting support for the Eldercare program. As a consequence, 36 members of the House and Senate became sponsors of Eldercare bills.

I still believe that the Eldercare plan serves the historic American principles of self-help and self-respect, for it allows the individual to make his own arrangements with his *own* money for the personal type of health care he himself decides upon.

Medicare backers continue to refer to the results of the November election as their "mandate" for medicare.

What about the mandate from the national poll, the Iowa and Colorado polls, and the hundreds of thousands of individually written letters and cards in favor of Eldercare?

Was not this outpouring of support for Eldercare at least a mandate for its consideration in Congress?

If the Administration really had a mandate for Medicare, why did it choose to make the measure a part of a "three-layer-cake" covered with as much frosting as it could possibly take?

The answer is simple. *Medicare never could stand on its own two feet!* It cannot stand alone now. It needs to ride on amendments and attachments: ideas *both* political parties supported in their 1964 platforms. The Medi-

carites hope Congressmen and Senators will vote for what is good in the entire measure, and Medicare will ride along.

Clever? Yes. A true vote on the merits of Medicare? No.

Remember that the bill which has passed the House will cost some 6.6 billion dollars. That is three times the estimated cost of the Medicare portion of the bill.

When and if the great cake is sliced, it may have a rich taste for some elderly. But for millions of employees and the self-employed the only slice they will get is one from their paychecks and from their earnings.

And what an expensive cake it will be for the nation. Next year the total Social Security tax deduction will bring in about 21.9 billion dollars, or almost 2.2 billion more than in 1965.

But then the cake for each succeeding year gets more expensive until the total Social Security tax take in 1972 reaches 33.2 billion dollars. That is an increase of more than 1.6 billion dollars a year to the taxpayers.

There's an old expression that you can't have your cake and eat it too. How true it is for the American taxpayer and the new three-layer-cake.

I have said repeatedly that there is no national emergency which can possibly justify the hasty consideration of such a sweeping measure, a proposal which inevitably would damage the quality of health care for the American people while adding billions of dollars to the heavy burden now carried by the nation's wage-earners.

Let me also emphasize to you that federal control of hospitals, and the medicine practiced in them lies at the heart of the "medicare" legislation.

Throughout the "medicare" bill *all* conditions of participation, and all other provisions, including services of hospitals, nursing homes and home health agencies, are controlled by the Secretary of Health, Education and Welfare.

These provisions make it clear that the Secretary will determine what is, and what is not, "reasonable cost" of services: he will command by rule and regulation whatever information he deems necessary and the methods by which it is provided.

Reviewing the many sections of the proposed "three-layer-cake" has convinced me that provision of health care to the elderly is of secondary importance and merely incidental to the underlying purpose of the bill.

The primary purpose seems to be to use the payment of tax funds to hospitals and nursing homes as a device to federalize the nation's hospital system.

The betterment of the public health was one of the goals the founding fathers of the American Medical Association were aiming for when the Association was organized in 1847. The betterment of the public health continues to be the Association's goal.

That is why the AMA has been speaking out on the health care issue, for the "medicare" tax proposal is bad legislation. It would *not* be conducive to the *betterment* of the public health. It would result in a deterioration in the quality of medical care.

My conclusion is that this "cake" should not have been concocted.

President Calvin: Dr. Appel, your address was excellent and informative. I can only say thank you for myself and for the delegation. Thank you.

I'll declare this recessed until Tuesday morning at nine o'clock.

(The meeting was concluded at 3:45 p.m.)

DINNER DANCE

Monday Evening, May 17, 1965

The speakers' section of the program was convened at 9:00 p.m. Mr. Richard I. Nevin was Toastmaster. The Honorable Walter H. Judd, M.D. was guest speaker. The title of his speech was *The Doctor's Role in Public Affairs.*

The Toastmaster: Ladies and Gentlemen: Before you address yourselves to the soup, may I have the pleasure of presenting the President of the Woman's Auxiliary to The Medical Society of New Jersey, Mrs. Philip J. Kunderman.

(Applause)

Mrs. Philip J. Kunderman: Thank you, Mr. Nevin.

On behalf of the Woman's Auxiliary to The Medical Society of New Jersey, I welcome you. I hope that you have a most enjoyable evening. The program is interesting. Please enjoy your dinner.

(Applause)

The Toastmaster: Ladies and Gentlemen: If you are ready, we will go on with the rest of the program.

First, let us speak of the principals of this evening's affair. One doesn't think or speak of Charlie Calvin without coupling references to Madolyn. They have accomplished, in a long and loving life together, a psychic integration tantamount to personal identification. Each thinks of and for the other, and both are well thought of in consequence. It seems to me their life theme is summed up in the poet's verse that says: "My true love has my heart, and I have his; each to the other given."

It has been a pleasure to find them as friends, and a sense of deep satisfaction to be in such close contact with them at work and at play through the year now ending. Their qualities are kindred and commonly shared: earnestness, constancy, affability, and—the most endearing—unpretentiousness. To them both in your name I express our gratefulness for a year of service to The Medical Society of New Jersey, and our hope that for thronging, blissful years they may continue to share, and enjoy life together.

(Applause)

Next, ladies and gentlemen, it is my privilege to call upon Dr. Jerome Kaufman to induct Dr. Calvin into the Society of Fellows of The Medical Society of New Jersey.

(Applause)

Dr. Jerome G. Kaufman: Mr. Toastmaster, Honored Guests, Members of The Medical Society of New Jersey, Ladies and Gentlemen:

The great philosopher Nietzche said, "The day cometh, the day goeth." The reverse of that is: "The day goeth and the day cometh." And tomorrow when it comes will be the end of the presidency of my good friend, Charlie Calvin, and many of the responsibilities which he has so well carried this year will disappear.

As a reward for his year of service, I have the pleasure of presenting to him the Fellow's Key and to let him cross over that river and join us, and I want to welcome him aboard.

I am particularly privileged because throughout my medical career, not only Charlie, but his dear wife Madolyn, have been parallel. She was a nurse at the Newark City Hospital; and Charlie, who was an intern, has followed me. One year after I accepted the Key, it is my pleasure and distinct privilege to give him this Key. I give it to him in appreciation not only from the members of the Board of Trustees, but from all the members of this Medical Society; and I bring to him their best wishes and my best wishes that Madolyn and he and his whole family may have the privilege of enjoying this Key . . . that God may grant them many years of good health.

Charlie, you're Key. Welcome aboard!

(Standing ovation)

President Calvin: Thank you.

The Toastmaster: You see, these procedures are fundamentally spiritual because the principle is apparently, "do unto others as others have done unto you."

Now it becomes Dr. Calvin's turn to present the Fellowette's Pin to Mrs. Philip Kunderman, the retiring President of the Woman's Auxiliary.

President Calvin: You know, Mrs. Kunderman and I haven't crossed paths too often this year, but I still know that she has done her job well; and I'm sure that she has enjoyed her year as much as I have enjoyed mine, although we're both glad it's over with.

And I was told when I was given this Pin, "Don't you dare pin it on her. Give it to her." (Laughter) You know, I was planning to carry this off with dash, but they wouldn't let me. So . . . Mrs. Kunderman, your Pin.

(Applause)

Mrs. Kunderman: Thank you very much, Dr. Calvin. I shall wear it proudly with the thoughts of this memorable evening and this very full year with its many new and fond associations.

On behalf of the Woman's Auxiliary to The Medical Society of New Jersey, I thank you, Dr. Calvin, and the Medical Society for your understanding help, your financial support, your guidance, and your many thoughtful kindnesses. I particularly wish to thank Mrs. Shirley Walsh, the Auxiliary Secretary, and Mr. Richard Nevin, the Executive Director of The Medical Society of New Jersey, for their many, many kindnesses and their great patience.

Thank you very, very much.

(Applause)

The Toastmaster: Ladies and Gentlemen: Thirteen years ago at the presidential banquet honoring Dr. Sigurd Johnsen, our speaker of the evening, with prophetic vision and clarion clarity, warned us of the relentless efforts of the Communists to enslave the world. He summoned us then to duty and responsibility.

Tonight he is with us again, in a time of intensified shadows that accompany the deepening twilight of the day of American independence and freedom.

Much of dire significance has occurred since last he spoke to us. Much has changed, but not this man of vision, humanitarian dedication, unimpeachable integrity, and forthright courage.

It is a great honor to present to you your speaker of the occasion—physician, missionary, politician, statesman, and peerless patriotic American—the Honorable Walter H. Judd, who will discuss "The Doctor's Role In Public Affairs."

(Standing ovation)

Dr. Walter H. Judd: Mr. Toastmaster, Presidents-elect of both sexes, and Doctors and your wives and guests—guests really of the Woman's Auxiliary:

It is, of course, a very great personal pleasure for me to be invited to speak a second time before The Medical Society of New Jersey, and I have been sitting next to Mrs. Fritts, President Fritts, who tells me that her county society is the oldest county society in the oldest State Medical Society in our country.

But it is a particularly special privilege for me always to have a chance to meet with those of my own profession, the profession in which I spent altogether as a student and as a general practitioner and general surgeon and man of all trades out in China twenty-six years altogether. I enjoyed those years as every person enjoys it when he has a chance to do something that he knows is being helpful to people.

Sometimes when I was being introduced to a political meeting the Chairman would say, "What shall I call you—Congressman, Doctor, Your Honor, or Your Excellency, or what?"

And I usually would say, "Well, just call me Doctor. I get called worse than any of those other ones. I earned this one, and I will have it after the others are gone."

I spent ten years as a medical missionary in China and twenty years as a missionary in the United States House of Representatives. (Laughter) And now I'm a missionary-at-large.

(Applause)

Perhaps you heard of the lady who was taking her first airplane ride, and she was a little apprehensive as almost everybody is on that first occasion. As luck would have it, they got into a violent storm and the plane just tossed around. Finally, she got panicky and turned to a clergyman sitting next to her. She said, "Father, you're a man of God. Can you do something about this?"

He said, "Lady, I'm in sales, not management." (Laughter)

So you are managing the medical profession. Now, I'm in sales for these years dealing as best I can with some of the basic ideas which made all this possible, and which are under assault today.

Another reason I treasure the invitation is because of the deep respect I have for this, my own profession. Years of scientific disciplines and daily experience with naked human beings—persons as they really are—have given most doctors habits of thought—cool heads; attitudes of mind—warm hearts; capacity to make decisions—courage; and capacity to carry through—still higher courage. These are precisely the qualities the nation needs so desperately in its leaders today—and so seldom finds.

Formerly, almost the sole reason for doctors to attend a medical convention was to learn about new concepts of disease, new drugs, new instruments, new technics—including new methods of dealing with old problems—that would enable us to practice our profession more skillfully and more successfully.

But medical meetings have changed—because times have changed. The doctor's job is bigger than was realized. The high quality of the professional attainments of today's doctors is beyond question. If there is reason for concern, it is more likely to be with respect to the quality of your citizenship. For that must be of a higher order than we have generally demonstrated in the past or there may not long be a free society in which you will have opportunity to use with success and satisfaction the knowledge and skills you have worked so long and diligently to acquire.

Our profession is going through the latest of several transitions in the last century. Originally, the doctor's main concern was with therapeutics. Since he didn't know too much about disease processes, it really amounted to treatment of symptoms

Then Loeffler discovered the diphtheria bacillus and Koch the tubercle bacillus. Virchow and others began doing autopsies systematically. It was proved that most symptoms were the result of demonstrable pathologic processes in various organs. The doctor began to shift his attention from results to causes, from therapeutics to diagnosis, from symptomatology to eitology.

This was the period in which I was trained 40 years ago. It was called the era of therapeutic nihilism. Our professors concentrated so much attention on the disease that we almost forgot the patient.

Then, with better understanding of how most diseases are caused and communicated, a third emphasis naturally developed – preventive medicine. The good doctor had to be an expert not only with the stethoscope and the microscope, but with the immunizing needle.

More recently there has been an increasing recognition of the effects of mind and emotions on physiological processes—and vice versa. The doctors who took care of only physiological and pathological processes were losing too many patients to those who paid attention also to people's emotions, and gave

them something to have faith in! Psychosomatic medicine belatedly came into its own. The AMA's new Department of Medicine and Religion is the latest evidence of this broadening of our concerns and concepts.

Now we have entered a fifth stage in this gradual metamorphosis — the doctor must give more attention to public affairs, or he will lose his professional freedom. During the depression of the 1930's, the hot war of the 1940's, the cold war of the 1950's, and the seductions of the 1960's, our Government has steadily expanded its activities until it now reaches into everybody's life and everybody's pocketbook almost every hour of every day. How and under what circumstances you are to practice your profession, what you will be able to earn, how much of what you earn will be permitted to keep, and what you will be able to do with when you are permitted to keep — all these depend more than ever before on what happens in Washington.

But many decisions in Washington depend on what happens in Cuba, or the Congo, or Korea, or Laos, or Berlin.

What happens in those places depends so largely on what is decided by men in Moscow and Peking.

And decisions in Moscow and Peking depend to a greater degree than we realize, I think, on what we do here in the United States — or what they *think* we will do.

Nobody in medicine needs to be apologetic today about discussing government. For unless we handle our affairs in such ways as to maintain freedom and peace in the world, there is no gain in America — medical, social, or otherwise — that will long be worth much to anybody.

Doctors must play a more active role in public affairs than medical people generally have — for at least three reasons:

First, to ensure our future as professional men and women; to safeguard the conditions under which we can use to best advantage our knowledge of disease and our skill in helping the sick.

Second, in order to work toward betterment of environmental conditions that affect adversely our patients. The man who comes with arthritis or an ulcer or hypertension frequently has something else wrong with him too. Perhaps he has a boy in Vietnam; or his business is in difficulty; or inflation has eaten up more than half of his life's savings; or he is apprehensive about nuclear war or atomic fallout. He knows his country is in trouble. He has legitimate anxieties. If we are really going to help him with *all* of his medical problems, we will have to pay more attention to the impact on him of his world environment, and try to influence that environment in the direction of making it more favorable to his well-being.

Third, we must play a larger role in public affairs in order to ensure our future as human beings. Before any of us are doctors, we are, like businessmen or lawyers, citizens of this Republic. Most of us are parents. All of us are taxpayers. All of us are trustees of a great and noble heritage of freedom — trustees of a political and economic order which made it possible for even those of us who came from humblest circumstances to get the expensive education which we could scarcely have dreamed of in most countries of the world. That heritage of freedom is gravely endangered both by skillful assault from without and by apathy and comfort within.

What we know as doctors about the practice of the healing arts should and must influence our thinking and our activities as citizens. But our obligations as citizens must also influence our thinking and conduct as doctors.

We talk much about what effect our Government's actions may have upon us. The time has come when we must give more thought to what effect we can and must have on our Government!

For instance, doctors, almost to a man, are opposed to socialized medicine — by which

term I mean tax-supported and Government-managed medical services. Most other people, I fear, assume that we oppose socialized medicine because we believe it would hurt the *doctors*. They think we are a closed-shop union that wants to have complete control of medical practice in order to promote our own selfish interests. We have failed to show the public that our opposition to socialized medicine is not because it would hurt us, but because it would hurt the *public*.

As a matter of fact, socialized medicine wouldn't hurt most medical people financially. The superior doctor will get ahead under any system. The average medical man would probably be about as well off financially under socialized medicine as under free competition. Furthermore, he wouldn't have to worry. He could get a fairly well-paid, Government-supported job right after internship, and continue in it for the rest of his life, with assurance of fairly regular promotions. The inferior doctor would be better off.

The public has been taught to believe by those who are more active in public affairs than we that socialized medicine would give more and better medical care at less cost. Doctors are sure it would give less and poorer medical care at greatest cost. For one thing, you would be so busy taking care of those who need your care least but demand it anyway "because it is paid for by the Government," that you would not be able to give proper time and care to those who need you most.

We in the healing profession tend to concentrate on improving the quality of medical care; those who don't understand the essentials of good care take high quality for granted and concentrate their attention on trying to get more equitable distribution. They don't realize that a main result of the supposedly better distribution when achieved by government compulsion is deterioration of the quality of the care. It is the patients who will suffer most, not the doctors.

It seems impossible for some in our country to believe that there still are professional people motivated more by concern for those they serve than for themselves. Yet, witness the way doctors have worked to eliminate or reduce the incidence of the diseases which it is their livelihood to treat. The beneficiaries of their spectacular success in eliminating diseases are not the doctors; the beneficiaries are the patients — at the expense of the doctors!

When has any profession ever worked so hard to reduce its own income? And for your reward, you have often suffered scurrilous misrepresentation by some of the very persons whose lives your efforts are prolonging.

So it is not because we are doctors that we oppose government-financed and managed medicine; it is because of what we know as doctors about the practice of medicine — the conditions that are essential if patients are to have first class medical care.

But it is not enough for us to be right. We must tell and sell our reasons to the public far better than we have. We can't do that by just talking to each other at medical meetings. We have to reach the public and the politicians, not to put something over on them, but to help them understand the true situation so that no one else can put something over on them.

But doctors must play a still broader role in public affairs. For example, who else can so well understand, and contribute so much to helping other citizens understand, the malignant nature of the Communist process which in less than 50 years has spread its blight over one-third of the world and threatens the remainder, including our own free America? If we fail here, we fail everywhere.

For there *is* on this planet a conspiracy dedicated to our destruction. The thing that makes a cancer bad is not its size or its location; it is the lawless way it grows. In practically all respects, the Communist movement behaves like other malignancies. It has rejected the normal processes of growth, and expands by lawlessly encroaching on tissues that don't

belong to it. Sometimes it is by direct invasion of an adjacent organ — or an adjoining country like Korea, Hungary, Tibet, Laos. Or it extends more stealthily by metastases — transplants of malignant cells lodging and working within other organs, or within other countries to disrupt their economy, subvert their thinking, weaken their institutions, in preparation for takeover.

To deal successfully with the present malignant threat to our survival, how urgently our country needs the kind of mind which his medical training has given the doctor.

First, the autopsy type of mind. Doctors have been trained to study the mistakes of the past and admit them openly, in order to learn from them. The doctor does autopsies not to cover up, but to correct. In government, the prevailing rule is not to correct, but to cover up. Each of the concessions we have made to the Soviet Union since World War I without firm insistence on substantial concessions in return, not just consiliatory words, has led to losses for freedom. Yet how many people in public affairs today, without your kind of mind, urge our government to keep trusting the same old pattern that the autopsy shows has always failed.

We also need in public affairs more men with the biopsy type of mind. When you look through a microscope and see some abnormal cells that have broken through the basement membrane in violation of normal laws of growth, you don't say, "Well, it's cancer all right, but let's wait and see if it spreads." You *know* it will spread unless you find ways to stop it at once and where it is. But during the last 4 decades, how many among our people have said, "Isn't it too bad what Hitler is doing to the Jews, or the Japanese are doing to the Chinese, or the Communists are doing to the Hungarians or Tibetans? But, after all, those places are a long way off. Let's see if we can't persuade the malignant elements to confine their efforts to the areas presently involved, and not spread to us." Could Hitler be malignant to the Jews and benign toward us? Can Communism be malignant to others, Tibetans, Laotians, Cubans, Hungarians, and benign toward us?

The doctor knows that in dealing with a cancer, there can be no end to the struggle until it or the body prevails. That does not mean that we must drop bombs on it. It does mean that, as a minimum, we have to isolate it by cutting off its blood supply, and the channels by which it transmits its lawless cells to other areas. Likewise, we must prevent the Communist cancer from winning new victories, such as expanded trade or diplomatic recognition would be for Red China, or admission into the United Nations before it qualifies by abandoning its lawless conduct.

While fighting the malignant process, the doctor knows that he must also build up the strength and health of the rest of the organism, the parts not involved — the resistance of the countries and peoples that are still free.

Doctors have been taught that almost the only unforgivable mistake for a physician to make is to underestimate the possible seriousness of a patient's condition. If we overestimate it, we are guilty of nothing but some undue caution. But if we underestimate it, the patient may be dead. The mistake is unforgivable because it is irretrievable.

Likewise, in the world struggle between lawless and law-abiding forces, it would be an unforgivable mistake to fail to understand the cancerous character of the Communist new growth — or to underestimate its strength, its determination, the dangerous inroads which it has already made into the organs of our Nation and the thinking of our people, without their realizing it. We must not make that mistake ourselves, and it is our duty as citizens not to let our fellow citizens make it. For it could be fatal.

It is equally essential that we not make the mistake of underestimating the strength of our own philosophy and faith — the basic soundness of the American system and its attraction and appeal to the oppressed millions of the earth.

What the world generally *wants* most from the United States is our wealth, our goods, our tools. But these are not what it *needs* most — for these are all results. What the world needs most from us is the secret that led to those results.

The secret of our wealth is an economic system which provides maximum opportunity and incentive for men to get ahead, to create, to produce, to expand, in order to improve their lives.

That economic system came from a political philosophy — the right of the individual.

That political philosophy in turn came from a religious faith — the belief that there is a Creator, and that every man is endowed by his Creator with certain unalienable rights arising from his importance and worth as a child of God.

We will not succeed in preserving the material results unless we revitalize and strengthen the spiritual roots from which the results came.

In short, we shall have to demonstrate as strong and deep a faith in our faith as the Communists have in theirs — and we shall have to work as hard and as skillfully to spread the truth as they work to spread their falsehoods.

To be successful in this effort, we must work both as individuals and as members of groups which we join and support, because they are dedicated to the causes in which we believe — religious groups, civic groups, political groups.

So often one finds doctors, unwilling, or too preoccupied, to work in political organizations. Yet if we are to expand our influence in public affairs, we must participate in politics, for it is politics that determines government — and government today determines the conditions of our lives as well as of our practice.

Therefore, join the political party of your choice — not because you think it is always right, but because you think it is nearest right on the most important issues. You won't agree with it on everything, any more than you agree on every issue with your church, or your medical society, or even with your wife. You don't pull out of those associations whenever you disagree. Rather, you stay in and try to move them in the direction you believe is better.

Just so, associate yourself with the party with whose principles and programs you find yourself in closest agreement, and work in and through it to help *s*elect, and then to help *e*lect, good men and women to public office at every level of government. It is votes at elections, not letters after elections, that have greatest influence on what a Congress does, because votes determine who is to be in the Congress.

Don't imagine you can do much to change the votes of Congressmen who were elected by those with views opposed to yours. Your job is to elect persons who already hold the same general view as you, and will work and vote for them.

That is, if you can't change the mind of your Congressman, then work to change your Congressman.

This requires that doctors become willing to be candidates for public office. That's rough, I can testify. But both patriotism and good sense require that *all* citizens, no matter how specialized their training, be willing to sacrifice their careers to go into public life as a public service, just as you were called at one time, and your sons are now being called, to sacrifice their careers to go into the armed forces as a public service.

Only as we do these things — not just discuss them, but *act* — will there be hope. The most wonderful thing about our country, the thing which we must preserve at all costs, is the privilege we have of changing the things we don't like. Thank God our system is such that wherever conditions are bad, or don't

meet our standards, we *can* correct them — *if we will work in public affairs.*

The way to begin is with ideas and principles, get persons and parties committed to them, translate them into programs, and put them into practice.

Please don't think I am trying to lecture you today. Rather, I am appealing to you for help. This patient is too sick to be saved without the intelligent and dedicated effort of all alert citizens. It particularly needs the leadership of men and women who have the qualities of mind and heart of the good physician — the cool head, the warm heart, the capacity to decide, and the courage to carry through.

The tests ahead will be harder that those of the past. But who is so well equipped to influence the attitudes and actions of our people as are you — in your dual role as doctors and as citizens? I am confident you will prove as resourceful and effective as citizens as I know you will as doctors. Freedom is worth it.

The Toastmaster: Thank you, Dr. Judd, for your wisdom and your inspiring spirit and example. You have deepened our already profound debt to you. God prosper you, sir.

Ladies and Gentlemen: I have one announcement. I extend to you in the name of JEMPAC an invitation to a breakfast tomorrow morning at 7:30 in the West Room, the second annual breakfast of JEMPAC. The invitation is extended to you to be the guests of the Medi-card, Incorporated, the new medical credit card plan, which is hosting the breakfast. Tomorrow morning Representative Durward Hall, of Missouri, who is also a distinguished physician-congressman, will discuss frankly and bluntly many of the problems presented by King-Anderson legislation, as well as the present challenge to, and the place of political education and action in, the physician's life, in a speech which he has titled "Medicine at the Crossroads."

That completes our formal program. The remainder of the evening and the music are yours to enjoy.

Thank you very much.

(Applause)

(The Speakers' Section was concluded at 10:18 p.m.)

Award For Best Article

A 10-day expenses-paid Caribbean vacation for two awaits the doctor who wins the top 1965 MEDICAL ECONOMICS Award for "the best original article by a physician." Two runners-up will receive cash Awards of $500 each. Since 1956, this competition has been stimulating physicians to share professional and personal experiences with their colleagues. This is the first year that a top Award other than cash has been offered to supplement regular payment for accepted manuscripts.

The winner can take the holiday at any time between December 1, 1965 and March 31, 1966. It includes round-trip air transportation for two to Jamaica, B.W.I.; a stay at the luxurious Half Moon Hotel; and such no-cost "extras" as a guided tour of Montego Bay and a flight to Port Antonio followed by a day's rafting down the Rio Grande.

August 31, 1965 is the deadline for submissions. Manuscripts, or requests for more information, should be mailed to: Awards Editor, MEDICAL ECONOMICS, Oradell, N.J. 07649.

MEDICAL-SURGICAL PLAN

Saturday, May 15, 1965, 5:00 p.m.

The open discussion on the Medical-Surgical Plan was convened at 5:00 p.m. Nicholas F. Alfano, M.D., President of Medical-Surgical Plan of New Jersey, presided.

President Calvin: I'm going to be very brief. Allow me to turn this meeting over to Dr. Thomas White, Chairman of the Board of The Medical-Surgical Plan.

Dr. Thomas White: Dr. Calvin, Members of the House of Delegates, Fellow Members of the State Medical Society:

As Chairman of the Blue Shield Board, it is my privilege to thank you on behalf of our members and our staff for this opportunity to come before you. Let me pause and recall my predecessor, Dr. Royal Schaaf, who served as Chairman of our Plan for many years, and who helped to make our Plan one of the country's outstanding ones. Dr. Schaaf not only did a magnificent job for our Blue Shield Plan, but he, at all times, was sensitive to the views and interests of the physicians of New Jersey. So I would feel remiss if I did not mention his name.

Also I may remind you, fortunately, that Dr. Lance, who was the first President of our Blue Shield Plan, is currently and actively a member of our Board of Trustees. And Dr. Sprague, present in the audience, is also one of the charter members of the Board, as is Mr. John Thompson. These gentlemen serve with distinction, with acute interest; and their historical knowledge of the Plan and its development continuously is of great aid to us in our current deliberations.

Likewise, we have on our Board three of the former presidents of The Medical Society of New Jersey, as well as the present holder of that office; in addition, two members of the Board of Trustees of the Society are also members of our Board of Trustees. So with these gentlemen of the medical profession and very competent laymen representing finance, business, industry, and educators we feel that we have a Board which is functioning very ably.

At many meetings over many years I have heard speakers discuss the lot of Medicine at the crossroads. Well, there are many types of crossroads. On our maps, some are printed in blue and some in red; some are secondary and some are primary. Now we are approaching a primary crossroad. But the map does not predict what lies ahead. We are confronted with an area that is not explored and has no marked out roads. We must be guided as best we can by our past experiences and our judgment as of today. But just as a traveler venturing into an unknown area has the guidance of the north star and his compass, so I believe that we of Blue Shield can be guided by our emblem, the Blue Shield, representing our concept of proper medical service; and for compass we have the integrity of our physicians. With these two guides I feel that, no matter what lies ahead, we should be able to maintain our position as leaders in the health insurance industry.

With these remarks, I will now call upon Dr. Alfano, the President of our Plan.

(Applause)

Dr. Nicholas F. Alfano: Thank you, Dr. White.

Dr. Calvin, Delegates, Members of the Medical Society, Ladies and Gentlemen: Several members of our staff are with us. If at any point a question arises which will require a more technical reply, I shall have the assistance of Dr. Rothgesser, Associate Medical Director; Mr. Romaine, Public Relations Officer; Dr. Comando, Physicians Relations Director; Mr. Laycock and Mr. Whalen, from Physicians Relations; our counsel, Mr. Vanderbilt; and other members of the Board of Trustees—Dr. Gleason, Dr. Borsher, Dr. Kauf-

man, Dr. McCall and Dr. Lloyd.

It gives me pleasure to welcome members of the profession to another of these forums which provide you, as individual physicians . . . and us, as administrators of Medical-Surgical Plan . . . the opportunity to discuss matters of common concern in an informal setting. Although some among you may differ occasionally with our approach, we all have the same end in view: the best possible Blue Shield Plan, consistent with certain delimiting realities. Anyone who speaks here today will, I am certain, offer his remarks within this constructive frame of reference.

This does not mean that we are trying to head off any throwing of brickbats. But we do suggest that if they are thrown, we should be able to use the bricks in helping to construct a stronger Blue Shield. Strengthening Blue Shield should be of just as much concern today to all of organized medicine . . . to each of you as an individual physician . . . as it is to the Plan's Trustees and administrative staff. And I certainly include non-participating physicians, as well as the Participating Physicians whose loyal support over the years has made possible the phenomenal growth of the Plan which today stands as the fifth largest of all 86 Blue Shield Plans within the United States.

Why is this matter of such importance to the entire medical profession? Because Blue Shield personifies organized medicine's concern for the patient who faces financial problems arising from illness or accident, at a time when he can least afford such additional problems. Blue Shield exemplifies the finest qualities of a fine profession. The entire medical profession is done credit by a good Blue Shield Plan. Conversely, when a Plan falters or loses ground, it reflects upon the profession which created it.

Every physician (whether he actively supports Blue Shield by participating or whether he remains on the sidelines—perhaps grumbling at the deficiencies of this "collection agency" which his colleagues make available to him) has a stake in Blue Shield's progress, its strength, its survival. If any one instrumentality is going to preserve the free enterprise system of American medical practice, it will be Blue Shield.

And as the profession needs a strong Blue Shield, so does Blue Shield need strong support from the profession. This interdependence means a sharing of hopes, aspirations, and problems, which is what we are here for today. Let me tell you first of some of our hopes and aspirations, together with a few of the reasons why it will take some little time to realize them.

Blue Shield's greatest need is to catch up to the medical economy of the times. Our Participating Physicians are overdue more realistic fees for most services. Our Subscribers should have service benefits income limits that are more in line with today's economy. The employers who pay all or part of the cost of their workers' protection are looking for greater flexibility on the part of Blue Shield in meeting their benefit needs. All of these we hope to achieve . . . in fact, we *must* achieve, if Blue Shield is to keep moving ahead.

For many months the Plan's Board of Trustees—and in particular its Fee Committee—has been engaged in the preparation of an up-to-date fee schedule, together with a new Subscription Contract offering some broader benefits. It had been our hope that this annual meeting of the Medical Society would be the occasion for announcing the filing of the new Contract and the adoption of the new Fee Schedule. Unfortunately, this has been delayed by some of the delimiting realities to which I referred earlier.

The Plan ended 1964 some half-million dollars in the red. Our reserves were down to only five weeks of normal operations. If this deficit trend continues . . . [and the first quarter figures for 1965 indicate that it is continuing] . . . this year will require a further invasion of reserves just to remain solvent, at the present rate of operation; further increase

of our liability through introduction of a higher fee schedule . . . which would cost an estimated additional half-million a year. This would almost certainly necessitate a rate increase or still further depletion of reserves.

Perhaps a deceptively simple solution occurs to some of you. If we all agree that more realistic fees are warranted, why not increase the subscription rate and adopt the higher fee schedule? Well, many of you must know about a bill that has been introduced in this year's Legislature . . . as it has every year for the last several . . . which would place control of fees paid to physicians by a medical service corporation in the hands of the Commissioner of Banking and Insurance. It is not difficult to imagine the effect on this now-dormant legislation if the Plan were to request a rate increase solely, or mostly, for the purpose of supporting a higher fee schedule, no matter what justifications we present for the increased fees. The fact that higher fees would benefit subscribers who were not eligible for service benefits (by covering a larger portion of the doctor's charges) would, I am afraid, receive short shrift as an argument.

Nor is the Plan likely to be granted rate relief for any reason, so long as there is even the most minimal reserve on the books, if we can judge by the experience of Blue Cross. That Plan did not receive much encouragement from the Department last fall when its reserves were down to little more than one week's normal operating expenses. As a matter of fact, a Bill was recently passed by the New York State Legislature, which reduces the mandatory reserve required of Blue Cross Plan, from 15 to 5 per cent of income. Were the New Jersey State Department of Banking and Insurance to use this as a yardstick in determining the fiscal soundness of the New Jersey Blue Shield Plan, it might permit our reserve to dwindle to $2 million or less before considering the need for rate relief. Such would ensure sufficient funds for only about 2 weeks of Plan oprations! In contrast, one of the membership requirements of NABSP is that member Plans strive to maintain as a minimum reserve sufficient funds equal to 3 months' operational costs.

So where does that leave the question of a new fee schedule and contract? As of here and now, there appear to be three possible eventualities.

The most optimistic is that the financial condition of the Plan will improve during the balance of the year to such an extent that we can offer the additional benefits contemplated in the new Contract, and adopt the new Fee Schedule without asking a rate increase or dangerously jeopardizing reserves. Only time will answer this, between now and fall.

The second possibility is that the financial condition will remain about the same for the balance of the year. In such case, the Board of Trustees might possibly consider the calculated risk of depleting the Plan's small reserves by filing the new Contract and adopting the new Fee Schedule without applying for a rate increase at the same time. However, such a course would almost certainly lead to the need for ultimate rate relief; how soon would depend upon the state of the reserves and the amount of increased liability incurred through the new Contract and Fee Schedule.

The third, and least attractive possibility, is that the Plan's financial and reserve position will worsen during the remainder of the year to the degree of requiring rate relief merely to meet our liabilities under the *existing Contract and Fee Schedule*. If this should happen, it is possible that we would file for a rate increase sufficient to support the new Contract and Fee Schedule, as well as catch up with the deficit operation existing at that time. This undoubtedly would necessitate application for a very substantial rate increase; how far the Department of Banking and Insurance would go along with such an application is a matter of conjecture.

To sum up in regard to a higher fee schedule:

1. The Plan's Trustees and Administration agree that higher fees are overdue.

2. We have prepared a schedule that we believe would be eminently satisfactory to 90 per cent of the physicians in New Jersey.

3. At our current rate of deficit operation, the additional liability created through the new fee schedule could dangerously deplete our reserves, unless the Plan were granted a rate increase.

4. The Department of Banking and Insurance would not look favorably upon a rate increase application for this purpose.

5. Should the Plan's financial condition improve between now and fall, the Trustees probably would adopt the new Fee Schedule without applying for a rate increase.

6. Should the financial condition remain about the same from now to fall, the Board might consider adopting the Fee Schedule without a rate increase application, but with the knowledge that the need for an increase would not be long in coming.

7. Should the financial condition worsen between now and fall, the Plan would be forced to seek rate relief to halt further deficits under the present structure; and while the application might be for an increase sufficient to support higher fees, it is questionable that the Department of Banking and Insurance would approve.

I am not going to conclude the discussion of this subject with another plea to be patient. Our Participating Physicians have every right to be *im*patient, at this point; and let me assure you that the Trustees and Administration are impatient to introduce these new fees. I have attempted to put all the facts before you, and not to mislead anyone by arousing false hopes. We cannot adopt a higher fee schedule immediately; what we will be able to do in the near future depends upon the emerged experience for the first quarter of this year and what it may portend as to our reserve position at year end.

The matter of more realistic income limits for service benefits is a subject to which we have devoted considerable study and planning. When the current Subscription Contract was introduced nine years ago, the income limits were $5,000 for a single subscriber and $1,500 for a family. These were among the most liberal of any Blue Shield Plan in the country. These limits made service benefits available to the great majority of our subscribers, possibly over 80 per cent of them, originally.

But as incomes have risen, more and more subscribers' incomes have passed beyond the limits for service benefits; or, to put it another way, the Plan's service benefits population has been shrinking.

This has been a matter of increasing concern to our Trustees and to the Plan's management, and to the National Association of Blue Shield Plans. The "service benefits" concept is the keystone of the entire Blue Shield philosophy. The National Association of Blue Shield Plans has adopted as one of its membership criteria the goal that a Plan should be able to provide service benefits coverage for at least 75 per cent of its enrolled population. We have been short of this goal for some years, but precise information was not available until very recently. The first such step was when the Internal Revenue Service agreed to make an analysis of subscriber incomes, based upon a sampling of subscribers' social security numbers. This indicated that among single contract holders in groups, 58 per cent had income within the $5,000 service benefits limit. For single direct payment subscribers, the percentage was a good deal higher: 74 per cent. Under family contracts, only 51 per cent of the group subscribers were at income levels that qualified for service benefits. For direct payment family subscribers, the comparable figure was 71 per cent.

Furthermore, these percentages are subject to even further reductions when viewed in the light of the current economy, since they are based upon income tax returns for 1962, the most recent of which was available for the study.

Subsequent to this Internal Revenue Service Study, an analysis was made by the Plan's Market Research Office. Let me summarize its conclusions, very briefly. Not only have incomes risen since the 1962 base of the study, but they are still rising. An income level that would make service benefits available to at least 75 per cent of the enrolled group population today (and for the next few years) would have to be in the vicinity of $7,000 for a single subscriber and $11,000 for a family contract. However, a comparable increase

would not be necessary for direct payment subscribers.

Naturally, we cannot contemplate higher income levels for service benefits without contemplating fees appropriate to the higher incomes. And we cannot contemplate the two together without recognizing that a higher subscription premium would be required. And this, in turn, might price out of the market those lower income subscribers who qualify for service benefits under our current criteria.

One of the possible solutions is this: The feasibility of introducing higher income levels, with commensurate increased fee schedules, by riders to the subscription contract. In this way, a subscriber with a family income of, for instance, $10,000 could purchase (through a rider) service benefits coverage within that income limit, and the Plan allowances would be commensurate with fees charged by physicians to non-insured patients in that income category. This mechanism would not add to the premium paid by the subscriber of lower income, who could still avail himself of service benefits under the lower, or existing, income limit.

This entire area requires thorough and time-consuming exploration. Certainly the overall concept would have to be acceptable to the Medical Society, and the fees related to income levels would have to be acceptable to the Plan's Participating Physicians. We must proceed with deliberate haste, and this we are doing.

A second possible solution is one introduced by the National Association of Blue Shield Plans. This is the "Prevailing Fee Program." This might be considered applicable to subscribers whose incomes exceed the Plan's current limits. Its distinguishing features include the elimination of fixed fee schedules and prescribed income provisions, and payments to physicians would be made in accordance with the physician's usual charge for a particular service. A careful study of its potentialities as a workable program appear to be reasonably attainable. Groundwork for development of the blue-prints for presentation to the Plan's Board of Trustees is presently being undertaken by our administrative staff.

The third important area—achieving more flexibility in the coverages we can offer group purchasers, specifically groups under National Account Contracts—is one that very possibly may govern the future of the Plan.

When the underwriting of Blue Shield was limited to our own state and virtually to a single contract form—as it was until very recently—our operations were relatively simple and uncomplicated. As a result, however, of the statutory extension of authority to us to participate in National Account underwriting, a new chapter in our corporate existence was opened up. The avenues for service to the public have been greatly enlarged.

A standard Blue Shield contract, capable of more or less general use, was developed in 1958 by the National Association of Blue Shield Plans. Various riders to this have been introduced subsequently. But even this package is not suitable in all instances to meet the employer's needs. Hence, when a national group comes into the market for a group health coverage, there usually must be negotiation, perhaps extensive, in order that:

1. The purchaser may obtain as nearly as possible the service contracts he needs and wants; and

2. Each Blue Shield Plan concerned may meet the need through some adjustment of its standard contract.

With the growing tendency of the purchaser to specify what he wants (rather than to limit his selection to the coverage immediately available) it is inevitable that custom made programs will become more numerous.

In the face of this rapidly changing approach to health underwriting, our need is some degree of diversification. Businesses of all kinds in this large, diversified, progressive country constantly strive to satisfy the vastly changing needs, wants and tastes of the public, subject to the varying incomes and resources of corporate and individual purchasers.

Blue Shield has been, fortunately, able to accomplish its existing status with comprehensive basic coverage and a modest assortment of riders. The reason is that the public has been strongly health insurance minded. Now that the most pressing and basic needs of the public in the health field are approaching saturation, the buyer is becoming more sophisticated in his choice. Blue Shield must be prepared to meet this new and natural development as it did with the Steel, Motors and Federal Employee groups within the recent few years.

This means that if Medical-Surgical Plan is to continue to grow and progress in step with the times, we will have to accommodate ourselves to increasing complexities in the prepaid health care field. We will have to make available a wider range of various benefit "packages," which will require specialization in a multiplicity of coverages for processing claims, to name just one area that will be affected.

It seems inevitable that our lives . . . physicians and Plan personnel alike . . . are going to become more complicated. That is the price that is exacted for progress in this increasingly complicated age in which we live. But it is a price we must pay, however unwillingly, or face the alternative of decay. I am confident that the medical profession does not intend, any more than do the Plan's Trustees and Administrative Staff, to let Blue Shield die by attrition.

You have done me the courtesy of listening to some of our problems, which in large measure you share with the Plan, and which together I know we will solve. I will now throw the meeting open to your questions and comments. Thank you.

May we have the first question?

Dr. Nathan S. Deutsch (Union): Dr. Alfano, have we done away with any thought of abandoning the "fee for service" benefit as a basic tenet of the Blue Shield Plans? How about an "indemnity" type of policy? Almost every type of insurance that I know of has a deductible feature. If you have a fire, you don't expect to collect one hundred per cent. No one could afford that kind of premium.

How about the indemnity? Is the Commissioner of Banking and Insurance still against us? I know Labor Unions are. And when you talk about income levels, remember that Labor just came out with something the other day in which they stated that an income of $6,500 for two adults and several children put a family in the "poverty" classification. To get out of the "poverty area," you'd have to go up a couple thousand dollars, and we still would be behind the eight-ball when it came to getting a fee schedule commensurate with what we'd like to have.

Dr. Alfano: Once we begin to consider abandoning the service benefit principle, Blue Shield may as well fold up. That is the one feature that enabled us to compete against insurance giants. It was the willingness of the medical profession to accept a fixed schedule of fees for people within prescribed income levels, as payments in full, that enabled us to grow within a period of twenty-five years to more than 50 million people covered in the United States. Basically, Blue Shield will always have its service benefit feature.

Dr. Madara (Salem County): I'm from one of the smallest counties in the State, the county that has the greatest ratio of participating physicians in the Medical-Surgical Plan. One of the prime problems in our small local hospital is our inability to obtain anesthesiologists. The chief reason is the low schedule of Blue Shield payments in comparison to that of surrounding states. We are right across the river from Wilmington, Delaware. The second trouble is that you won't let us bill for services of a nurse-anesthesiologist who gives the anesthesia. I have been told that there is a clause in the contract which would allow a group of anesthesiologists to bill for services rendered by a nurse anesthetist. I'd like to see if this is true. This is under Section 9 of the contract agreement plan: "Payment for services under this contract may be made directly to

the subscriber following acceptable proof of rendition of services if"—and then paragraph B says—"The charge for such services is made directly or indirectly by a corporation, hospital clinic, or group which includes other than participating physicians or is made by any person other than a participating physician who personally rendered the services."

I'd like to ask two questions: Are the Medical-Surgical fees for anesthesiologists enforced throughout the State? And second, is it true that a nurse anesthetist may bill the Plan directly?

Dr. Alfano: In many areas, we are behind in our payments, and it was with this in mind that our Board of Trustees assigned to a Fee Committee the task of reviewing the entire schedule to come up to more reasonable levels in line with today's economy. We are doing everything possible to get that fee schedule into operation as soon as possible. Within the last two years, our minimum fee for anesthesia was increased by $5. But every increase has to be made within a rate structure that was established by the Commissioner in 1956. We had some relief in 1961 which approximated an overall fifteen per cent increase, but that was only after the commissioner had reduced our premium by five per cent only two years previously. So that we don't have presently funds sufficient to bring our fees up to what we consider a reasonable level for the subscribers within the income limits prescribed in the contract.

Now with respect to your second question: The law itself, our Enabling Act, limits us to payment for services personally rendered by physicians. The law has been amended in the past several years to include among physicians payment by a Medical Service Corporation for services rendered by chiropodists, more recently to dentists. But we cannot pay a nurse anesthetist. Section 9 refers to a hospital or incorporated group. We have in mind such places as the Lahey Clinic, in which the doctors are full time, in which the payments revert to the entire clinic. In such instances, when we receive claims from the Lahey Clinic or the Carrier Clinic, we make payment directly to the subscriber under the terms of that provision. Perhaps our counsel, Mr. Vanderbilt, would want to amplify the interpretation of that provision.

Mr. Vanderbilt: I believe you have covered it.

Dr. Robert H. Areson (Essex): Doctor, I'm interested in a little bit of the philosophy of the Medical-Surgical Plan. If we are working to 75 per cent coverage on a "service" basis, you are going to put yourself in the position of not being able to take care of those people for whom the Plan was primarily designed. I'd like to know where the figure of 75 per cent of the wage earners covered came from. I would like to know if the conclusion from that is not true, that you would then place yourself in a position of not being able to provide a full service to the lesser income people who may not be able to afford your Plan payment. Do I make myself clear?

Dr. Alfano: I do not know whether there is any scientific basis for the 75 per cent figure. It was always felt that a good functioning Blue Shield Plan should be covering, with the income limit it establishes, around 75 per cent of its enrolled population. It is important to stress that word "enrolled." About 70 per cent of our enrollment is group enrollment. These are working people, mostly in industry. By no means do they make up the wealthy in New Jersey. Perhaps they are of moderate means. Some come within the medium income levels; but they are still the working population.

Dr. Areson: I think that explains it. I was concerned about the expression "seventy per cent of the wage earners." This is seventy per cent of those who are "enrolled" in the Plan get full service benefit.

Dr. Alfano: Any further questions? If not, we'll make our meeting a short one, too.

Thank you very much.

(The meeting was concluded at 5:50 p.m.)

ATTENDANCE

REGISTRATION OF HOUSE OF DELEGATES

Attendance at House Sessions

Registration:			
Total Possible—Officers, Fellows, and County Delegates		364	
Total Possible of County Delegates	341		100%
Total County Delegates Registered	328		96.2% (*)

Attendance of County Delegates at the House Sessions		% of Possible	% of Registered
1st Session, 5/15/65	(292)	85.6% (*)	89.1% (*)
2nd Session, 5/16/65	(321)	94.1% (*)	98.4% (*)
3rd Session, 5/18/65 a.m.	(282)	82.7% (*)	86.0%
p.m.	(260)	76.2%	79.3% (*)
Average for All Sessions	(289)	84.8% (*)	88.1% (**)

(*—Highest on record)
(**—Higher than 1964)

OFFICIAL ATTENDANCE REPORT

County	Delegates	Members	Total
Atlantic	8	71	79
Bergen	35	40	75
Burlington	7	14	21
Camden	19	26	45
Cape May	2	3	5
Cumberland	5	10	15
Essex	68	131	199
Gloucester	4	11	15
Hudson	30	38	68
Hunterdon	3	4	7
Mercer	22	59	81
Middlesex	17	37	54
Monmouth	16	48	64
Morris	14	23	37
Ocean	6	13	19
Passaic	29	31	60
Salem	3	11	14
Somerset	5	16	21
Sussex	3	1	4
Union	29	46	75
Warren	3	4	7
Fellows and Officers	19	—	19
	347	637	984
Physician Guests			83
Physician Exhibitors			42
TOTAL PHYSICIAN REGISTRATION			1,109
Auxiliary—Members, 390, Guests, 50			440
Visitors			324
Exhibitors			282
TOTAL REGISTRATION			2,155

FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1965	1,109	1,046	2,155
1964	1,040	966	2,006
1963	1,018	973	1,991
1962	1,208	1,083	2,291
1961	1,134	1,115	2,249

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Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect – Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:
3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

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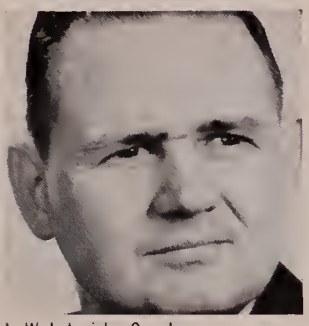
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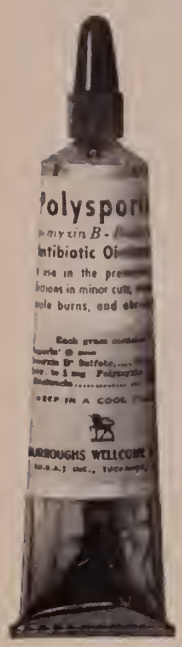
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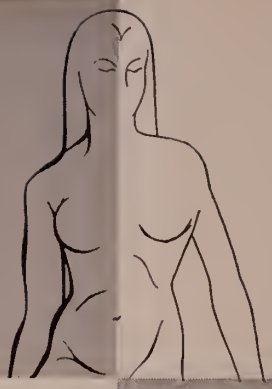
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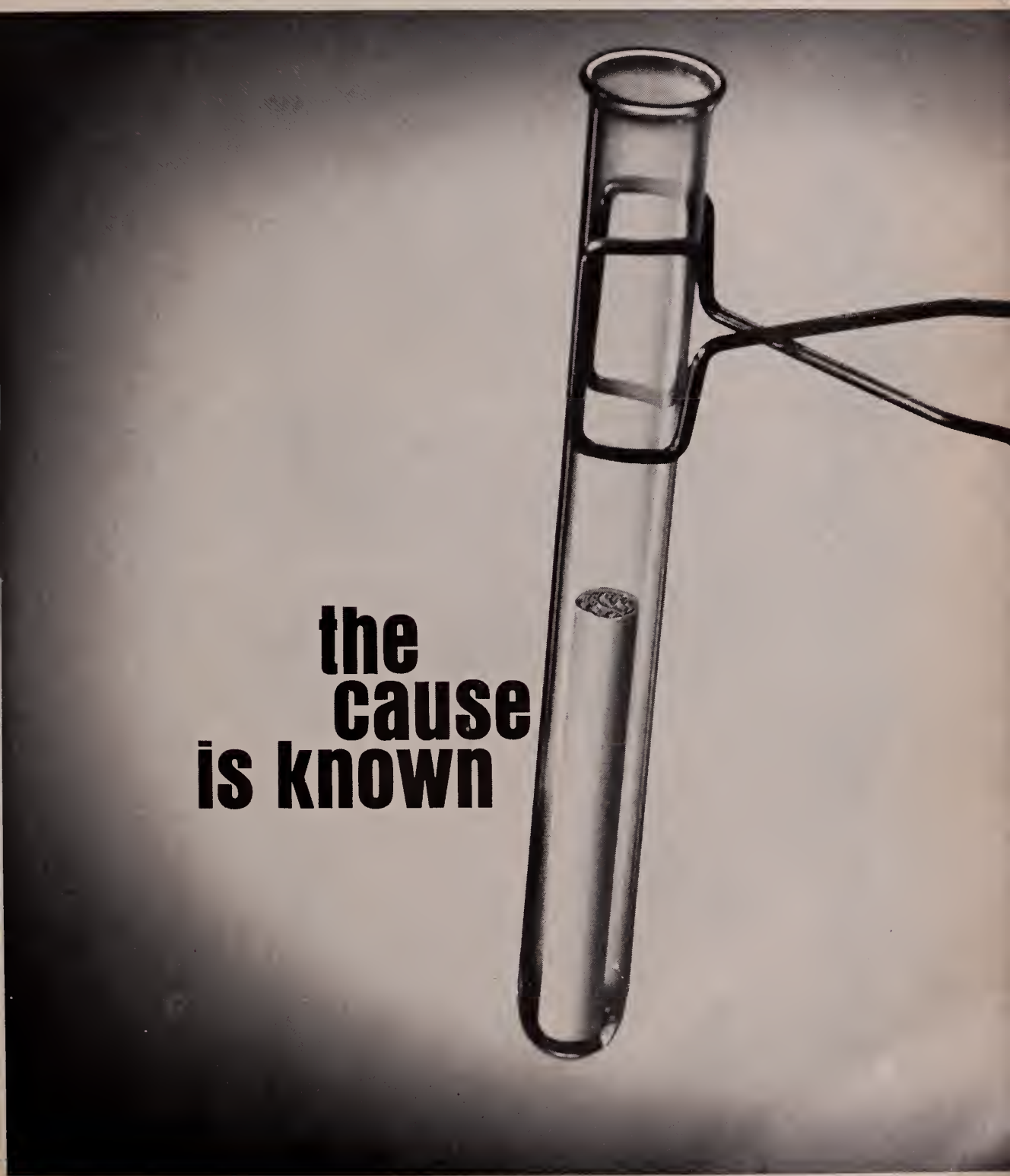
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Ralph N. Lee, M.D., Veterans Administration Hospital, Fort Howard, Maryland. Howard University Medical School 1960. General surgical residency. Available July 1965.

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Mario Ludmer, M.D., 256 Highland Avenue, Pittsburgh, Pa. 15229. University of Buenos Aires School of Medicine 1956. Board eligible. Available immediately.

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Edward G. Krug, M.D., 142 Merson Drive, Buchanan, Michigan 49107. Wayne State University 1958. Available immediately.

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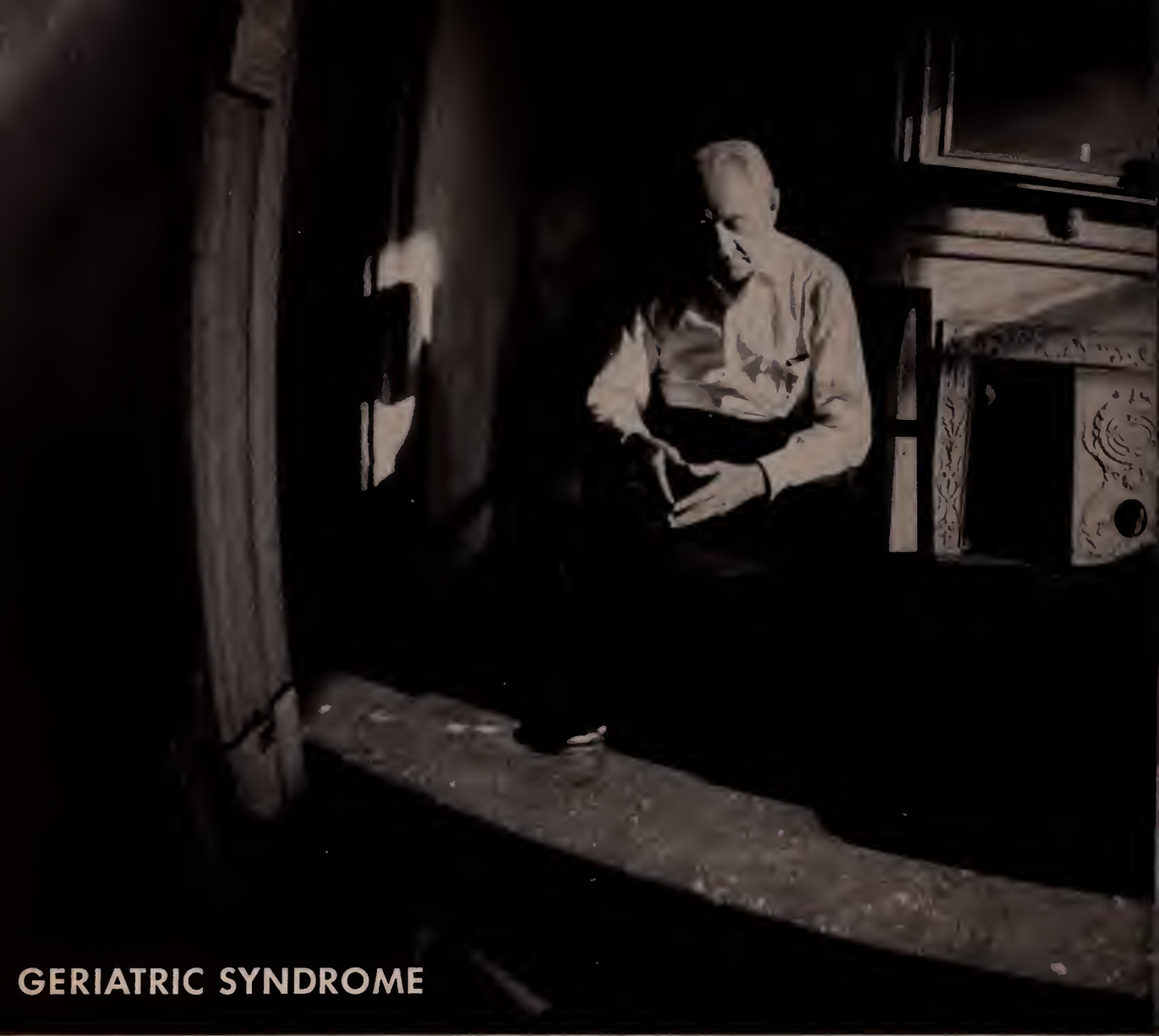
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*This one at Oak Creek, Castle Rocl., Arizona

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0.0194 mg.	atropine sulfate	0.0582 mg.	16.2 mg. (¼ gr.)	phenobarbital (¾ gr.)	48.6 mg.

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Gasping for air can cause an understandable degree of apprehension in the asthmatic. Improved ventilation together with patient acceptance of medication provide an atmosphere of freedom. OPTIPHYLLIN fills this need in the management of bronchial asthma, emphysema and other pulmonary disorders associated with bronchospasm.

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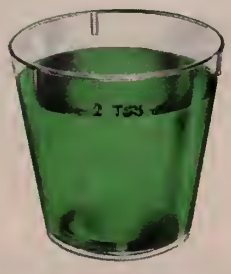


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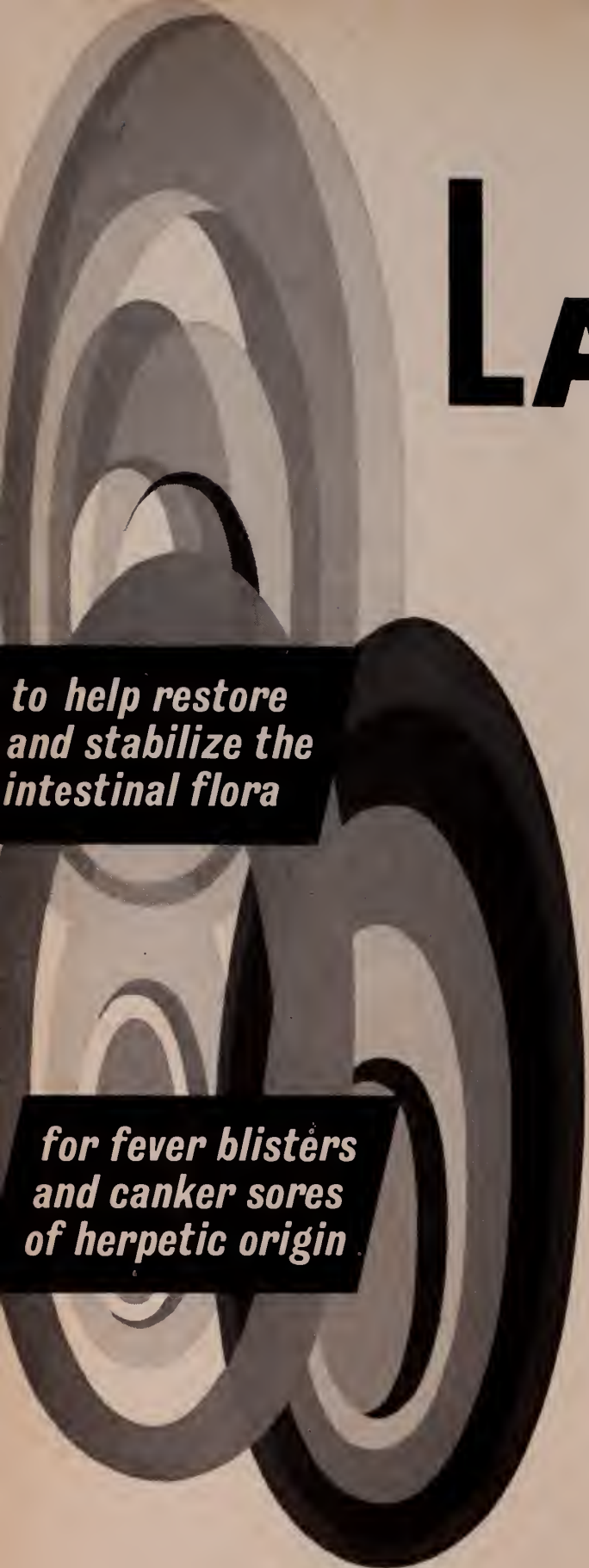
ge (Calibrated dosage cup dispensed with each prescription) 15 ml. (1 tablespoonful) contains theophylline 80 mg., 20% alcohol.
adult dose in acute asthma attacks is 75 ml. of OPTIPHYLLIN, ded theophylline in any form has not been given in the preceding urs. A maintenance dose of 30 ml. of OPTIPHYLLIN can be initiated hours later and maintained t.i.d. Maintenance doses in chronic onary conditions associated with bronchospasm and in emphysema from 45 ml. to 30 ml. t.i.d.
ediatric dose in acute asthma is 0.5 ml. per pound of body weight, be repeated in less than 6 hours, and not more than 2 such dosages given in 24 hours. Maintenance dosage varies from 0.3 ml. to 0.2 ml. ound of body weight t.i.d. until therapeutic effect is obtained.
PHYLLIN is best absorbed on an empty stomach. *(Since nausea omiting usually herald early signs of excessively high theophylline l levels, these manifestations should serve as early warning signs duce or discontinue further administration of* OPTIPHYLLIN.)
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for fever blisters and canker sores of herpetic origin

LACTINEX—a viable culture containing both *Lactobacillus acidophilus* and *L. bulgaricus*—was first introduced to help restore the flora of the intestinal tract in infants and adults.[1, 2, 3, 4]

Further clinical work showed LACTINEX to be successful in the treatment of fever blisters and canker sores of herpetic origin.[4, 5, 6, 7]

No untoward side effects have been reported in 12 years of clinical use.

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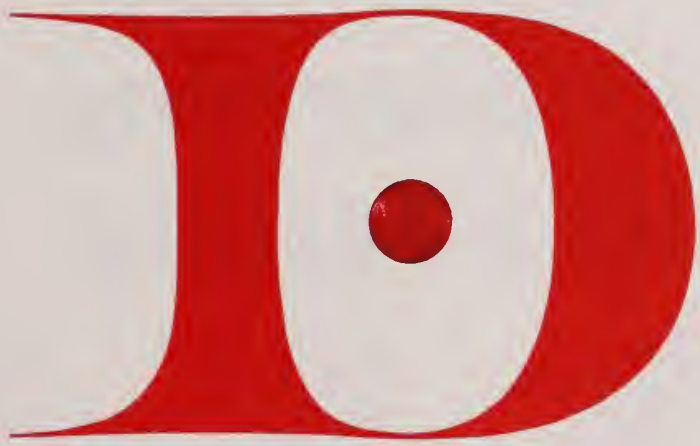
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Available dosage forms: Film Coated Tablets containing 150 mg. and 300 mg. demethylchlortetracycline HCl.

ACTION: DECLOMYCIN Demethylchlortetracycline is a broad-spectrum antibiotic derived from a strain of *Streptomyces aureofaciens*. Demethylchlortetracycline is closely related chemically to tetracycline and has been shown to have several advantages which make it a valuable aid to antimicrobial therapeutics. It has a greater antibiotic potency which makes it possible to achieve therapeutic activity with less weight of antibiotic. It has a greater stability in body fluids due to a slow degradation. It has been shown to have a reduced renal clearance rate which produces a prolongation of the antibacterial levels in the body.

The average adult daily dose of DECLOMYCIN Demethylchlortetracycline (600 mg.) may be considered to be the equivalent of 1,000 mg. of tetracycline per day.

INDICATIONS: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

The following conditions have been successfully treated:

Abscess
Acne
Bronchiectasis
Bronchiolitis
Bronchitis
Bronchopulmonary Infection
Cellulitis
Cystitis
Endometritis
Erysipelas
Furunculosis
Genitourinary Infection
Laryngotracheitis
Mixed Bacterial Infection
Non-Specific Urethritis
Otitis (Externa or Media)
Pharyngitis
Pneumonia
Pre- and Postoperative Prophylaxis of Infection
Primary Atypical Pneumonia
Primary and Secondary Syphilis
Pustular Folliculitis
Pyelonephritis
Pyoderma
Sinusitis
Streptococcal Sore Throat
Tonsillitis

associated with tetracycline-sensitive organisms such as the following:

Eaton Agent
Endamoeba histolytica
Hemophilus influenzae
Pneumococci
Escherichia coli
Gonococci
Shigellae
Staphylococci
Streptococci

Evaluation in other infections and conditions is continuing.

DECLOMYCIN Demethylchlortetracycline is indicated for surgical and dental preoperative and postoperative prophylaxis of infection in contaminated fields. Since penicillin is the drug of choice for syphilis and gonorrhea, it should be employed in these infections except in patients with a history of penicillin allergy.

In cases of acute gonococcal urethritis where a primary or secondary lesion of syphilis is suspected, proper diagnostic procedures including darkfield examination should be followed. In all other cases where concomitant syphilis is suspected, serological tests should be made monthly for at least three months.

In patients with agammaglobulinemia or hypogammaglobulinemia and recurring infections, it is necessary to treat with both gamma globulin and an antibiotic such as DECLOMYCIN Demethylchlortetracycline.

DECLOMYCIN Demethylchlortetracycline shows activity against some strains of *Pseudomonas* and *Proteus* heretofore unresponsive to tetracycline therapy as shown by both *in vivo* and *in vitro* studies.

In the treatment of staphylococcus infections, indicated surgical procedures must be performed in all cases.

WARNING: If renal impairment exists, even usual oral or parenteral doses may lead to excessive systemic accumulation of the drug and possible liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, demethylchlortetracycline serum level determinations may be advisable.[1,2,3]

A photodynamic reaction precipitated by direct exposure to natural or artificial sunlight has been observed in some individuals. Small amounts of drug and short exposure to these sources of sunlight may produce an exaggerated sunburn reaction which may range from erythema over the exposed parts of the body to severe skin manifestations. In a smaller proportion, photoallergic reactions to this drug, as well as other tetracycline derivatives, have also been reported.

Such patients should be warned to avoid direct exposure to natural or artificial sunlight while under treatment and to discontinue the drug at the first evidence of skin discomfort.

Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

PRECAUTIONS AND SIDE EFFECTS: The use of antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.

Demethylchlortetracycline may form a stable calcium complex in any bone forming tissue with no serious harmful effects reported thus far in humans. However, use of demethylchlortetracycline during tooth development (= last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (=yellow-grey-brownish). This effect occurs mostly during long-term use of the drug but it has also been observed in usual short treatment courses.

As with all other antibiotics, side reactions which might be encountered include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Rare cases of anaphylactoid reactions have been reported following demethylchlortetracycline. Appropriate precaution is advised.

With full therapeutic doses in infants, increased cranial pressure with bulging fontanels has been observed. The frequency has been rare and all signs and symptoms have disappeared rapidly upon cessation of treatment.

ADMINISTRATION AND DOSAGE: *ADULT:* The average daily adult dosage is 4 divided doses of 150 mg. each or 2 divided doses of 300 mg. each.

An initial dose of 300 mg. may be used in the more severe infections, but a single dose exceeding 300 mg. is thought to be unnecessary.

INFANTS AND CHILDREN: The dosage is 3 to 6 mg. per pound body weight per day or 6 to 12 mg. per Kg. per day, divided into 2 or 4 doses dependent upon the severity of the disease. This should not be given with milk formula or other calcium containing foods and should be given at least one hour prior to feeding.

Because of the cumulative effect in the body, continuation of high doses beyond the first few days is thought to be unnecessary.

Therapy should be continued beyond the time when characteristic symptoms or fever have subsided; however, DECLOMYCIN Demethylchlortetracycline, because of its unique property of prolonged stability in body fluids, permits serum activity for 24 to 48 hours after the last dose. The incidence of rheumatic fever or glomerulonephritis following streptococcal infections suggests that therapy of a streptococcal infection should be continued for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.[4,5,6]

In the treatment of pustular acne vulgaris an initial dose of 600 mg. daily for one or two weeks may, in most cases, be reduced to 300 mg. or 150 mg. daily for remainder of treatment course.[7]

Absorption is impaired by the concomitant administration of high calcium content drugs such as some antacid medications, foods and some dairy products such as milk. Oral forms of demethylchlortetracycline should be given 1 hour before or 2 hours after meals.

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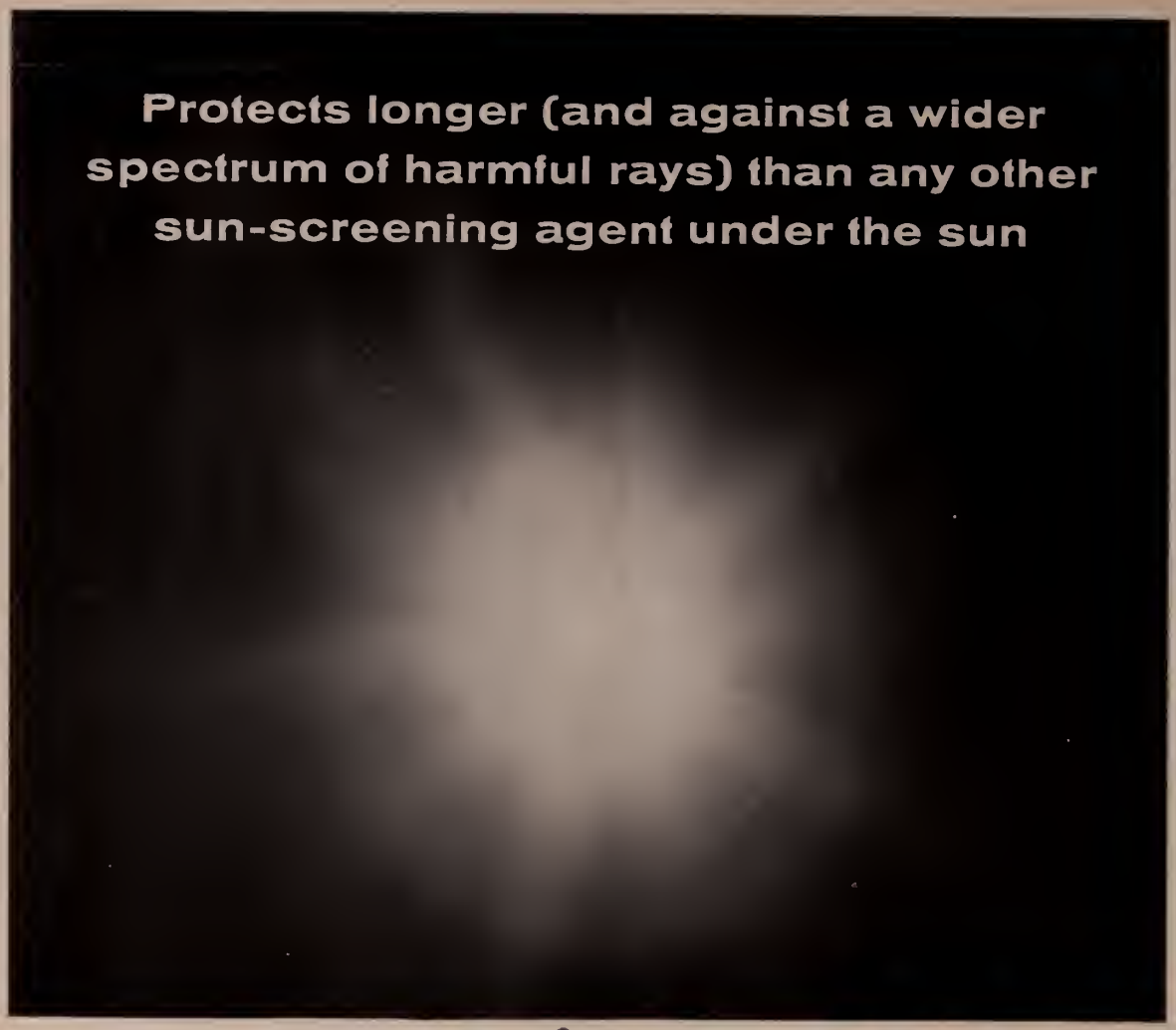
Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects*, usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

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Therapeutic effects
A number of investigators report improvement in about 75% of cases. Relief of pain and stiffness is the predominant response. Frequently, there is also a significant improvement in function. The beneficial effects of the drug are usually seen by the third or fourth day of treatment.

There is general agreement that milder cases of osteoarthritis are preferably treated by simple analgesics. In many patients, however, this mode of therapy fails to give sufficient relief. Because steroids are not very effective in this form of arthritis, phenylbutazone affords the drug therapy most capable of relieving the more severe cases. For best results, it is recommended that treatment with phenylbutazone be combined with physiotherapy and other appropriate supportive measures.

Dosage
The initial daily dosage in adults is 300-600 mg. in divided daily doses. In most instances, 400 mg. daily is sufficient for maximum therapeutic response. A trial period of one week is adequate to determine the effects of the drug; if there is no improvement, discontinue the drug. When improvement does occur, dosage should be promptly decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning: If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
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EDITORIALS

One Patient At A Time

It is one of the glories of free American medicine that we treat each patient as an individual—meet his medical needs one at a time and attend to our patients one at a time. This seems to be the decent, humane, and compassionate way of practicing. But increasingly, our profession is faced with the problems of disaster medicine—not only medical and surgical care in man-made disasters (like wars and riots), but also in "natural" calamities like tornadoes and floods, and accidental ones like explosions, fires, and collapses of bridges and dams.

The doctor, faced with a truck load of patients brought to him at once, has to think of triage: of sorting the victims in some kind of priority order. He has to decide who gets first treatment and he has to learn how to handle many casualties at once. Yet nothing in conventional medical-surgical training has taught him about triage, about determining treatment priorities or about mass treatment.*

Training efforts are now being made, either through formal lecture and demonstration programs or through rehearsals of hospital disaster plans. But attendance at such drills is sparse, and many physicians don't take the rehearsal seriously. The physician is traditionally willing to assume total responsibility for medical care of individual patients in his office, his hospital, and sometimes even in the patient's home. It is, however, hard for him to adjust to the notion that he has responsibility for the care of people, not "his" patients, at distant disaster sites.

Other groups are ready to assume leadership if doctors leave a vacuum. First aid squads, emergency room nurses, policemen, firemen, Red Cross workers, scout leaders, and in some places even chiropractors are willing to take over this kind of emergency responsibility if they are asked. It would seem that under present precarious conditions, all physicians—even the most exquisitely specialized ones—should learn something of the technics of triage, first aid, mass emergency care, and even community organization. If we don't take on this training and the resultant chores, other groups will.

Quality Control For Physicians

The following editorial is abstracted from the May 1, 1965 *New York State Journal of Medicine:*

Medical audit is a recent term that has produced its share of misunderstanding and apprehension. What is medical audit?

It is an appraisal of the quality of care rendered by practicing physicians. Its ultimate purpose is to keep medical care at a high standard.

It offers an approach specifically designed to ensure that physicians retain the right to evaluate their own professional efforts.

In 1963 the Medical Society of the State of New York backed legislation authorizing medical audits and spelling out guarantees that protect physicians and hospitals from any possibility of suits arising out of information given for medical audits. Such information has been declared inadmissible in any legal proceeding. Anyone who supplies information for audits is safe from ". . . any action for damages or other relief."

Internal medical audits are a part of the work

* At the AMA's "Disaster Medical Care Conference, November 8, 1964, Dr. Francis C. Jackson reported that "in a recent review of 35 surgical curricula in medical schools, only 19 indicated that their students had any experience in emergency rooms."

of ever," medical records and tissue committee. What is new is the medical audit performed by physician-teams with no organizational ties to the hospitals they survey.

The first external audit under the 1963 law is now under way in the 11-county Rochester hospital region. Teams of obstetricians and pediatricians are studying obstetric care and care of the newborn among 1,300 infants born in all 29 general hospitals of that region. This and all succeeding audits under this program are sponsored by the Medical Society's research arm, the Empire State Medical, Scientific, and Educational Foundation. The State Health Department is supplying technical personnel and funds.

To ensure absolute confidentiality, hospital medical records librarians are inking out the names of patients and physicians before any record leaves the hospital. The Medical Society and the State Health Department have pledged not to publish medical findings that identify patient, physician, or hospital. Planners of medical audits have foreseen that anything less than total anonymity would destroy their value as a teaching tool.

The Rochester audit will try to spot clues to why infant death rates have failed to decline in the last ten years. The Medical Society of the State of New York believes that once problems are located, practicing physicians will join in a concerted effort to seek solutions with their county societies, hospital medical staffs, and related organizations.

The individual practitioner has a big stake in medical audits. They offer him a way in which he can retain the right to evaluate his own patient-care performance.

Growing interest by government, labor unions, and insurance groups has made it clear that someone will be examining the quality of medical care more carefully in our age. That someone should be the physician, who is the best qualified and the most deeply concerned with improving the quality of medical care. Viewed this way — and with the State Health Department's considerable contribution to the effort — medical audit shapes up as an exceptional bargain.

Women In White

When doctors more and more take to wearing "business suits" instead of white jackets in their office; when even some orders of nuns permit the sisters to depart from their traditional habit; when Navy nurses and "Visiting" nurses wear blue instead of white; when psychiatric wards experiment with nurses wearing street clothes rather than uniforms—when all this happens, it is too much to expect that hospital nurses will be content with starched white uniforms. For the last four years, the pediatric nurses at the Gainesville (Florida) Clinic have been wearing colored dresses and ordinary ("street") shoes and stockings on duty.* Taking a second look at the program, the nurses, their little patients, and the patients' parents (and, one assumes, the interns) are all in favor of expanding the experiment to all parts of the hospital.

The original idea was that white symbolized cleanliness, which—as any driver of a white automobile knows—isn't always so. White is also worn by chefs, street cleaners, and Good Humor men. The theory was that white uniforms had a soothing effect on children and a solacing effect on nervous adults. Experience at Gainesville has shown that this just wasn't true. Children felt more secure with women in conventional dresses. In one statistical survey, it was shown that, while doctors were peering into their ears and mouths, children sat more contentedly on the laps of nurses wearing colored dresses than on the laps of women in white.

Next step: fashion designers stylizing special frocks (not uniforms) for nurses . . . Well, why not? A little color often brings a lot of good cheer.

* July 16, 1965 issue of *Hospitals* (Journal of the American Hospital Association).

ORIGINAL ARTICLES

Here's the kind of situation where careful diagnosis saves lives. And Dr. DiBenedetto tells us just how.

Subphrenic Abscess

Anthony DiBenedetto, M.D.*/Elizabeth

During the past seven years, we have had seventeen cases of subphrenic abscess. Our experiences here reflect the advances of the surgical care of the critically ill patient developed over the past twenty years. As a result of improvements in total care, many patients can now survive a number of consecutive complications of which subphernic abscess is only one (Table I).

TABLE I

SUMMARY OF THE PATIENT'S ILLNESS

1. Gastrectomy for hemorrhage due to duodenal ulcer†
   Acute postoperative pancreatitis
   Closure of evisceration, drainage of duodenal fistula
   Tracheostomy for staphylococcal pneumonia
2. Cholecystectomy and common duct exploration
   Drainage of subhepatic hematoma
   Exploration for gastrointestinal bleeding and splenectomy (operative injury)
   Drainage of left subphrenic abscess
3. Cecostomy for acute large bowel obstruction with cecal perforation
   Intestinal obstruction treated by intubation
   Resection of transverse colon and spleen for carcinoma
   Drainage of left subphrenic abscess
4. Staphylococcal pneumonia and empyema—left side
   Closed thoracotomy for drainage—left side
   Drainage left subphrenic abscess anterior extraserous approach
5. Resection left adrenal cyst
   Bronchoscopy for atelectasis
   Drainage left subphrenic abscess
   Emergency splenectomy for hemorrhage from the splenic artery
   Reduction of jejunal volvulus and subtotal gastrectomy for bleeding duodenal ulcer
   Drainage recurrent subphrenic abscess
6. Esophagogastrectomy and splenectomy for carcinoma esophagogastric juncture
   Drainage left subphrenic abscess
   Drainage recurrent abscess
7. Pancreaticoduodenectomy for carcinoma of duodenum
   Drainage subhepatic abscess
8. Cholecystectomy
   Drainage right subphrenic abscess
9. Perforated ulcer
   Drainage right anterior subphrenic abscess
10. Esophagogastrectomy, splenectomy, partial pancreatectomy for carcinoma of the cardioesophageal juncture
    Drainage left subphrenic abscess
    Lysis of adhesions causing small bowel obstruction
11. Appendectomy for acute appendicitis
    Drainage pelvic abscess
    Drainage of right anterior subphrenic space
    Toxic hepatitis
    Re-exploration right subcostal and abdominal incisions
12. Acute appendicitis, unoperated (patient delay)
    Drainage of right posterior subphrenic abscess
    Elective appendectomy
13. Right hemicolectomy for hemorrhage due to diverticuli
    Drainage of right subhepatic and right anterior subphrenic abscess with resection of anastomotic breakdown and reanastomosis via transabdominal approach
14. Resection splenic flexure and spleen for carcinoma
    Drainage left subphrenic abscess
15. Gastrectomy for bleeding ulcer†
    Exploration for postoperative intra-abdominal bleeding
    Bronchoscopy
    Tracheostomy and assisted ventilation
    Exploration for small bowel obstruction
    Small bowel resection for obstruction due to peritonitis
16. Cholecystectomy and common duct exploration
    Drainage of infected wound and closure of wound dehiscence
    Drainage left subphrenic abscess
17. Closure perforated ulcer
    Drainage right subphrenic abscess and subtotal gastrectomy for reperforation of duodenal ulcer associated with bleeding duodenal ulcer
    Gram negative septicemia and shock

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† Died with undrained right subphrenic abscess

The diagnosis, often difficult in these patients, rests on understanding of and familiarity with the anatomy and pathologic physiology of this disease. Ochsner and DeBakey[1] wrote the classic paper on this in 1938. Many later reports include cases from the pre-antibiotic era, and therefore do not do full justice to modern surgical practice. Gerwig and Blades[2] reported (in 1956) that although the diagnosis was often made more difficult because of antibiotic therapy, they were able successfully to make the diagnosis, and treat the disease without mortality. Our own experience would seem to confirm this. Fifteen patients whose abscesses were drained survived; in two patients in whom the abscess was not suspected, death ensued. Autopsy confirmed this.

Anatomy

Under normal conditions there are no true spaces in the subdiaphragmatic region. It is only when these potential spaces are converted into actual spaces by air or fluid that they become the source of potential infection. Classically, pus may accumulate in seven such areas in the upper abdomen.

The liver divides this region into two general areas: (a) that between the liver and the diaphragm being the *superior;* and (b) that between the liver and the transverse colon, the *inferior.* The falciform ligament separates this area into right and left and as it attaches to the right lobe of the liver as the coronary ligament, creates spaces anteriorly and posteriorly. Between its leaves on the right is the extra-peritoneal or "bare area" of the liver. On the right side as traditionally described there are four spaces where an abscess may collect: inferior or subhepatic, anterior superior, posterior superior, and the "bare area." On the left side, the stomach divides the subdiaphragmatic region into anterior and posterior spaces, the latter being the lesser omental sac. The area between the left lobe and diaphragm is the left superior space.

Right	*Left*
Inferior or subhepatic	Superior
Anterior superior	Anterior inferior
Posterior superior	Posterior inferior
Bare area	

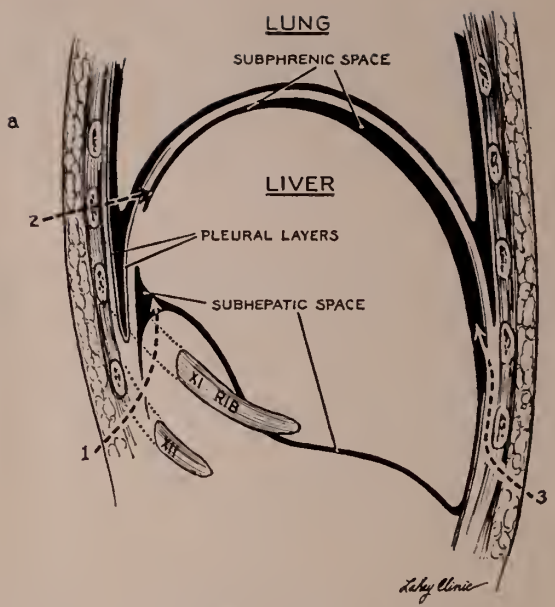


FIGURE 1: This drawing depicts accurately the anatomy of the right subphrenic and subhepatic area. Comparison with Figure 2 will show the clinical extent of the subphrenic space. Reproduced with the kind permission of Dr. David P. Boyd and the W. B. Saunders Company, publisher.

This description has been accepted for many years and is the terminology used in the older surgical literature. Boyd,[3] however, reaffirmed the fact that the posterior superior space on the right in reality does not exist, since the coronary ligament suspends the liver from the dorsal portion of the diaphragm and abdominal wall (Figure 1). According to this concept, the area anterior to the coronary ligament is the anterior superior space, and that posterior to the ligament is the inferior or subhepatic space.

Boyd[3] further describes these large superior and inferior spaces as being subdivided by pyogenic membranes which localize the abscess either in the anterior or the posterior portions of the superior or inferior space. On the left side he described only two spaces: anterior and posterior, the latter being the lesser omental bursa.

Our own observations during operation and in the postmortem room confirm Boyd's description. Radiologic evidence (Figure 2) in two patients with subphrenic abscess reveals clearly the true extent of the right subphrenic space and the fact that the liver is suspended from the posterior abdominal wall.

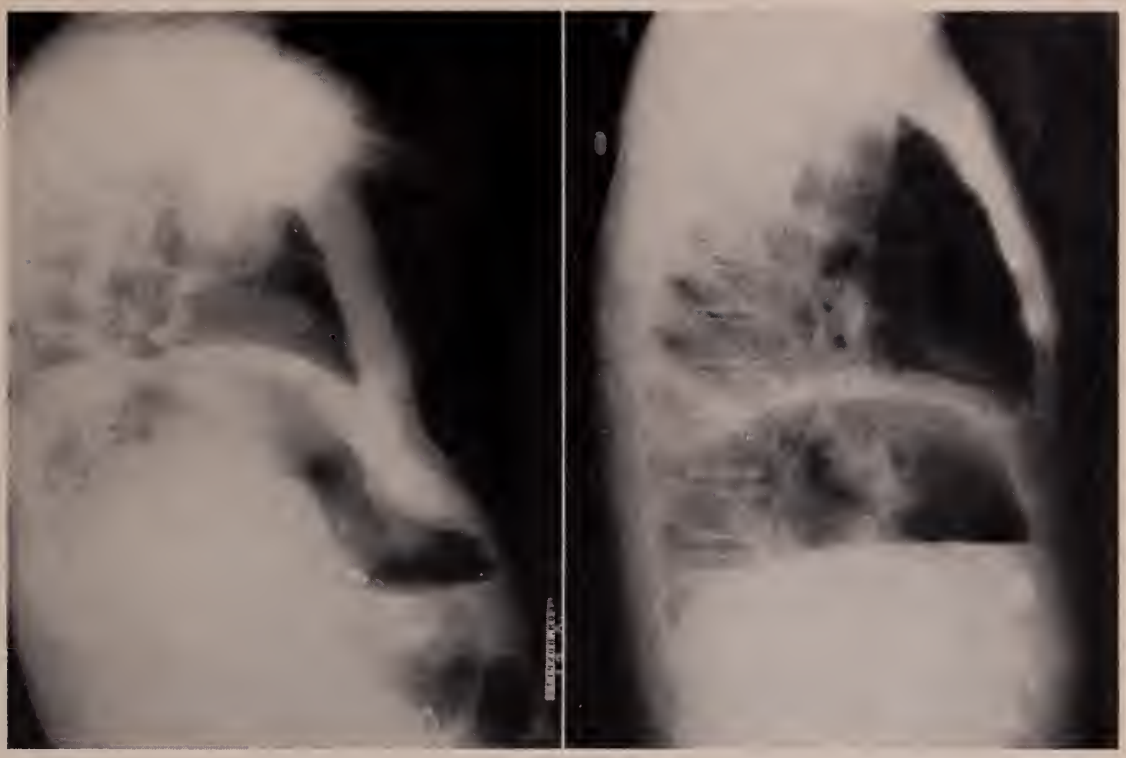


FIGURE 2: A.: Case 13. Shows actual extent of superior subphrenic space as outlined by air prior to drainage.

B.: Case 9. Prior to drainage. The position of attachment of the liver posteriorly and extent of superior space can be clearly seen.

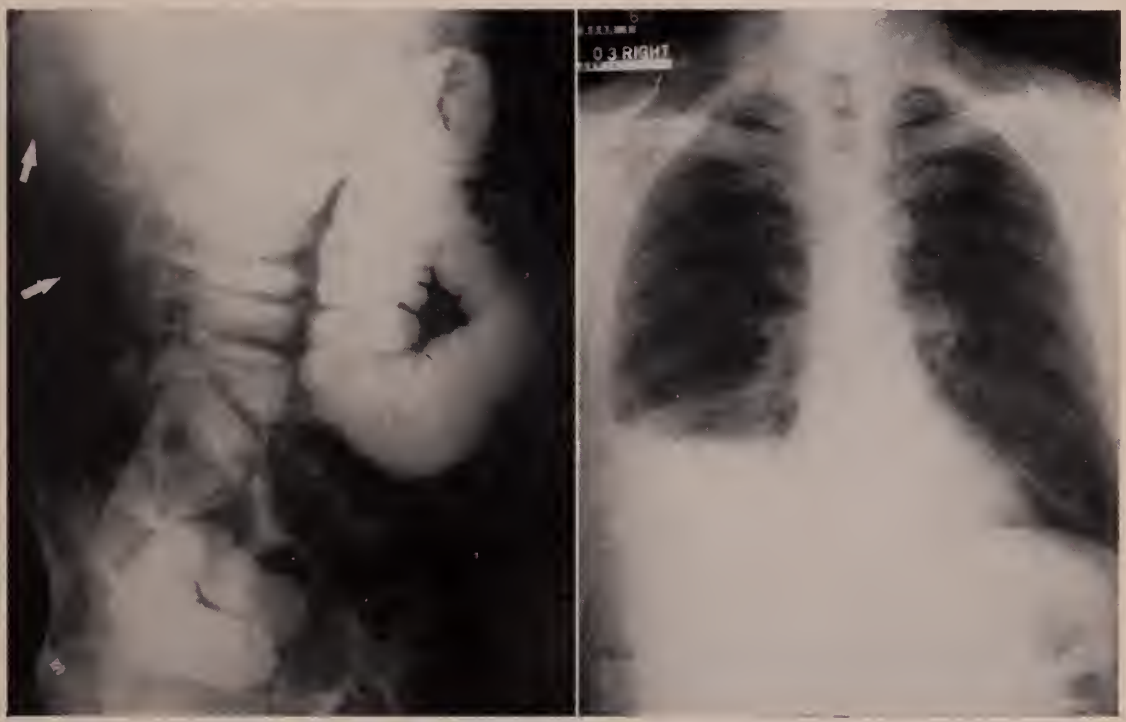


FIGURE 3: A.: Case 12. Shows retrocecal appendix with gas bubbles extending towards diaphragm.

B.: Case 12. Radiograph prior to drainage of subphrenic abscess.

TABLE II

Case	Inciting Cause	Location of Abscess	Type of Drainage	Fluid Level	Result
1.	Gastrectomy for bleeding ulcer	Right anterior subphrenic	None	No	Died
2.	Cholecystectomy and choledochostomy	Left posterior	Post-extraserous	No	Satisfactory
3.	Resection transverse colon and spleen	Left posterior	Post-extraserous	No	Satisfactory
4.	Staphylococcal pneumonia and empyema	Left anterior	Ant-extraserous Post-extraserous	No	Satisfactory
5.	Resection left adrenal cyst	Left posterior	Post-extraserous	No	Satisfactory
6.	Esophagogastrectomy and splenectomy for carcinoma	Left*	Post-extraserous	Yes	Satisfactory
7.	Pancreaticoduodenectomy for carcinoma of the duodenum	Right inferior or sub-hepatic	Ant-extraserous	No	Satisfactory
8.	Cholecystectomy	Right anterior subphrenic	Ant-extraserous	Yes	Satisfactory
9.	Perforated ulcer unoperated	Right anterior subphrenic	Ant-extraserous	Yes	Satisfactory
10.	Esophagogastrectomy, splenectomy, partial pancreatectomy for carcinoma	Left*	Post-extraserous	Yes	Satisfactory
11.	Appendectomy for acute appendicitis	Right anterior subphrenic	Ant-extraserous	No**	Satisfactory
12.	Acute retrocecal appendicitis, unoperated	Right posterior subphrenic	Post-extraserous	No	Satisfactory
13.	Right hemicolectomy for hemorrhage	Right subhepatic and right anterior subphrenic	Intraperitoneal	Yes	Satisfactory
14.	Resection carcinoma splenic flexure and spleen	Left*	Ant-extraserous	Yes	Satisfactory
15.	Gastrectomy for bleeding ulcer	Right anterior subphrenic	None	Yes	Died
16.	Cholecystectomy	Left posterior	Post-extraserous	No	Satisfactory
17.	Perforated ulcer	Right anterior subphrenic	Intraperitoneal	Yes	Satisfactory

BOYD'S CLASSIFICATION

Right Side

Anterior portion } of supra-hepatic or subphrenic space
Posterior portion }

Anterior portion } of subhepatic space
Posterior portion }

Bare Area

Left Side

Anterior
Posterior

Etiology

The inciting cause of subphrenic abscess in this series is listed in Table 2. In nine patients, elective surgery for a variety of lesions led to this complication. Five patients had had emergency surgery and three of those developed abscesses. Of the seven patients with left-sided lesions, four had splenectomy at the original operation, and one had splenectomy following operative injury during a surgical procedure for a complication which preceded the development of the abscess. A number of these patients had multiple complications of which subphrenic abscess was only one, and required several operative procedures during the course of their illness (Table 1).

E. coli was cultured at the time of drainage in nine patients. In three patients, E. coli was present with another organism: Staphylococcus albus in two, and Proteus in one. Staphylococcus aureus was recovered in pure culture in two, while S. albus was present alone

*Cases No. 6, 10 and 14 can be classed only as left.
**Sterile fluid drained.

TABLE III

CLASSICAL COMPLICATIONS OF SUBPHRENIC ABSCESS

Rupture into the peritoneal cavity
Empyema
Subdiaphragmatic bronchopulmonary fistula
Rupture into the pericardial sac
Liver abscess
Septicemia

COMPLICATIONS OF SUBPHRENIC ABSCESS SEEN IN THIS GROUP OF PATIENTS

Hemorrhage from the splenic artery: Case 5
Reaccumulation of abscess: Cases 5, 6, 12

TABLE IV

BACTERIOLOGY

Case

1. E. coli and staph albus
2. B. proteus
3. Staph aureus coagulase positive
4. E. coli
5. Staph albus coagulase negative
6. E. coli and staph albus coagulase negative
7. No culture
8. E. coli
9. E. coli
10. Staph albus coagulase negative
11. Sterile
12. E. coli, B. proteus
13. E. coli
14. E. coli
15. Staph aureus coagulase positive
16. Enterococcus
17. E. coli

in two. Proteus and enterococcus occurred alone in one case each. One abscess was sterile, and in one patient the pus was not cultured (Table 4).

Only two of this entire group of patients had *not* been on antibiotics. Both presented with well-developed abscesses, one complicating an untreated perforated ulcer; the other undiagnosed acute appendicitis in the retrocecal position.

Diagnosis

The key to successful diagnosis is diligent search. Once suspicion has been aroused, frequent examination of the patient is imperative. The most consistent and reliable clinical finding in this group was tenderness over the area involved. There was tenderness over the costal arch in the anterior abscesses and tenderness over the eleventh and twelfth rib in those situated posteriorly, except in one patient. All showed elevation of temperature and blood count at some time prior to drainage. This included patients on antibiotics. In several instances the clinical picture of infection became more dramatic after the antibiotic therapy previously instituted was terminated.

An air fluid level under the diaphragm was apparent in eight patients. Pleural reaction ranging from blunting of the costophrenic angle to large effusion was present in eight other patients. In only one instance was there complete absence of pleural reaction and fluid. In this patient with a subhepatic abscess, there was normal diaphragmatic function during fluoroscopy.

The two undiagnosed abscesses in this group were also in patients with pleural effusion and costal arch tenderness on the right side along with clinical evidence of infection. The complexity of their illness, however, diverted our attention from the subphrenic area and led us to ascribe these findings to other causes.

Needle aspiration was not deliberately used for diagnosis. In two cases, however, accidental aspiration of pus in the course of thoracentesis led to the correct diagnosis. On both occasions, because of the strong suspicion of subphrenic infection, the thoracentesis was repeated at a higher level with the aspiration of clear serous fluid. This indicated that we were not dealing with empyema, but with subphrenic abscess. In neither case did empyema develop as a result of the transpleural aspiration of the abscess. To place any reliance on needle aspiration would be fraught with hazard, since failure to aspirate pus would not rule out the possibility of subphrenic abscess. If there is strong suspicion of subphrenic abscess, surgical exploration is indicated, since failure to detect and treat this condition leads to fatality. This is an accepted surgical principle, and there should be little hesitation on the part of the surgeon to follow this course. Our own experience supports this concept, since the only fatalities occurred in two patients whose abscesses were not discovered until autopsy was done.

Choice of Surgical Approach

Authoritative opinion[1] on subphrenic abscess favors the extraperitoneal[4] approach for drainage.[5] Antibiotics, although diminishing somewhat the penalties for the intraperitoneal approach, do not change this basic concept, in our opinion. In only two of our patients was the transperitoneal approach used. In one of these, anastomotic breakdown had occurred following resection of the cecum and ascending colon. The entire problem was managed transabdominally by resecting the leaking anastomosis and draining the associated subphrenic abscess. In the second, reperforation of a previously sutured perforated ulcer occurred, requiring subtotal gastrectomy at the same time as drainage. Both patients recovered.

The choice of anterior or posterior approach was made on the basis of location of the abscess as determined by the clinical and radiologic findings. If a mass was present (as it was in one patient) or if an air fluid level was present (as in eight cases), then the approach was rather clear. In the absence of air fluid level or a mass, the site of the associated tenderness was a reliable guide in determining whether the abscess was anterior or posterior.

We have not used the Trendelenburg (or transpleural) approach, although it is advocated by some as the most direct route to the posterior portion of the right subphrenic space. We have had no difficulty in exploring the subphrenic area through the posterior extraperitoneal route as described by Ochsner,[1] nor have we had great difficulty in stripping the peritoneum from the entire surface of the diaphragm to enter the bare area on the right side through the anterior extraperitoneal approach. Although such an approach may take more effort, the extra time and perseverance seem worthwhile. It is necessary, however, that the incision be generous enough to permit the entire hand to enter. A limitation of the anterior approach is that it is impossible to explore the posterior portion of the subhepatic space without risking entry into the peritoneal cavity. On the other hand, the posterior approach through the bed of the twelfth rib allows exploration of the bare area, the posterior portion of the subpherenic area on the right side, and in addition, if the inflammatory induration is palpated in the subhepatic area, an abscess in this location can be evacuated. Where diagnosis or exact location is uncertain, the transperitoneal approach is indicated, since the consequences of not finding the abscess would be far more serious than those of peritoneal contamination.

Postoperative Care

There is little in the literature concerning the care of the drained abscess. One would expect that following drainage, recovery would be smooth and rapid. This is not always the case, however, and recovery may often be protracted. In several of our patients, the abscess space took a long time to obliterate; and in three cases, the pus reaccumulated. After evacuation, the abscess space is often a large one, maintained by thick inflammatory walls which do not readily collapse. Constant care is required to prevent the drainage opening from sealing over before obliteration of the cavity occurs. Although large bore drainage tubes have been recommended, we have used by preference a number of Penrose drains with loose closure of the wound around them. After removal of the drains in about ten days, the drainage tract is kept open by frequent finger dilatation and irrigation, through catheters of appropriate size.

Complications of Dainage

Reaccumulation occurred in three patients about six weeks after initial drainage. These patients complained of fever and lassitude with tenderness over the drainage incision. All the late reaccumulations occurred in cases where *posterior* drainage had been done. Drainage occurred spontaneously at home in one. In the other two, drainage was instituted as an office procedure when they were seen with tenderness and fullness in the healed incision associated with elevated temperature and pain several weeks after hospital discharge. Two to three hundred cubic centi-

meters of purulent material drained in each instance, with complete and immediate relief of fever and with the rapid return of the feeling of well-being. Drainage sites were then diligently kept open until final closure occurred.

Bleeding from the splenic artery led to a harrowing complication in one man. He developed a subphrenic abscess after excision of a large left adrenal cyst transperitoneally. To get adequate exposure, the spleen and pancreas were mobilized. At the time of drainage, some bleeding occurred during the breakdown of loculations with the finger, which we ascribed to oozing from the abscess wall. A loose, two-inch gauze pack was placed in the space. On the sixth day following, there was bright red blood accumulating in the dressing, the patient rapidly developing the clinical picture of shock due to hemorrhage. He was taken to the operating room, at which time the packing was slowly removed. The posterior drainage incision was enlarged, after which active arterial hemorrhage could be seen coming from the eroded splenic artery. Splenectomy was done, the splenic artery being ligated proximal to the eroded area.

The spleen would seem to be a hazard in the posterior drainage approach for a left-sided abscess. The splenic pulp may be punctured unknowingly, since when involved in infection it may become friable and a portion of it forms part of the abscess wall. In four of the left-sided abscesses in this group (drained by the posterior approach) the spleen had been removed previously.

Discussion

The most common cause of subphrenic abscess in the pre-antibiotic period was peritonitis due to perforated appendix and perforated ulcer.[1] It now occurs most frequently after elective surgery. This does not necessarily mean that the antibiotics alone have been responsible for this change in etiology. Advances in the early diagnosis and treatment of appendicitis and perforated ulcer, combined with all the developments in pre- and post-operative care, have been equally responsible for lowering the incidence of this complication in those diseases.

With the extension of abdominal surgery which these same advances have permitted, extended surgical procedures involving the upper abdomen have become commonplace. More frequent splenectomy in association with excisional surgery of adjacent organs creates a space which seems especially prone to abscess formation in our experience. It also is apparent that in a number of these patients, subphrenic abscess is the result of the final loculation of diffuse peritonitis made possible by the ability of the patient to reach this point in convalescence by the antibiotics and the general supportive care now available.

Our material also points out that subphrenic abscess often occurs as one of a number of complications, any one of which untreated would be fatal. It is in these difficult problems with multiple complications that the utmost vigilance for subphrenic abscess must be maintained. In such cases one will achieve the greatest salvage. Table 1, a sketch of each patient's clinical course, indicates the complexity of the problems involved. A total of 39 complications occurred in this group, most of which required operative intervention. Many patients such as these would have succumbed early in the course of their illness had they been treated twenty or more years ago.

The use of antibiotics in the seriously ill and complicated surgical patient, who is most likely to develop subphrenic abscess,[6] may alter the clinical course of these patients.[2] The diagnosis may be made difficult as a result of the suppression of the clinical signs of infection; however, the diagnostic signs are present though they must be searched for more diligently. Altemeier[7] has been concerned with the mixed blessings of antibiotics and has proposed their withdrawal on the suspicion of hidden infection, in order to allow the purulent collection to signal its location. This policy would seem to have considerable merit in spite of the temptation to add other antibiotics or increase the dosage when the signs of infection are present. It is a policy which

requires considerable restraint by the surgeon, but one which might be most rewarding in its ultimate benefit to the patient were the diagnosis made earlier because of it.

We have found it helpful to culture the contents of all organs opened in the performance of resectional surgery. Sensitivity to specific antibiotics is determined for any organisms found, so that, if required, antibiotic therapy will be on a rational basis. We have not considered the mere presence of organisms, however, as an indication for the use of these agents in the post-operative period in the absence of clinical signs of infection.

Awareness of the possibility of reaccumulation of the drained abscess is of great importance, especially if the original surgery was for malignant disease. If the initial drainage site was anterior, the presence of a mass some months later in such a patient may cause the erroneous assumption of metastatic malignant disease to be made, when in fact the mass may be a recurrent subphrenic abscess.

That this area should be explored without hesitation and procrastination when the findings warrant or when there is only suspicion is a well-accepted principle. Dineen[8] found *no survivors among untreated patients with subphrenic abscess.* The only deaths in our group of patients occurred in the two with untreated subphrenic abscess. This underscores Dineen's observation. One should be willing to accept gracefully an occasional negative exploration when the clinical course and signs are suggestive of subphrenic abscess in view of the substantiated lethal nature of the unrecognized abscess.

Summary

1. Seventeen patients with subphrenic abscess occurring in the past seven years are here reported, thirteen following upper abdominal surgery.

2. All patients whose abscess was drained survived. The two patients whose abscess was unrecognized died. Autopsy confirmed the subphrenic abscess in both these patients.

3. The most consistent clinical sign was tenderness over the area involved, associated with evidence of infection. Radiologic evidence of subdiaphragmatic infection was present in all but one. The diagnostic features and the difficulties created by the use of antibiotics and complex illnesses are discussed in the text.

4. The unusual complication of hemorrhage from necrotic erosion of the splenic artery after drainage was encountered in one patient and was successfully treated by emergency splenectomy. Reaccumulation of the abscess occurred in three patients, all of whom had been treated by posterior extraserous drainage.

5. The location of the abscesses was not as classically described. In only one of our group was the abscess in the posterior subphrenic space, the most commonly affected space in the pre-antibiotic era.

6. The extra-peritoneal approach still remains the method of choice for drainage where the location of the abscess is known. When the exact location is in doubt, or there is an associated process which demands correction, the transperitoneal approach is indicated.

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Acknowledgment

Cases 1 through 14 are from the Surgical Service of the South Nassau Community Hospital, Rockville Center, New York, and the Shell Surgical Group, Freeport, New York.

204 South Broad Street

Something really new is not often reported in the medical literature. Here, however, is an instrument and a procedure that may well merit this characterization.

Advances in the Diagnosis of Gastric Lesions*

Fibergastroscopy and Cinefibergastroscopy

Victor W. Groisser, M.D./Montclair
John Di Bianco, M.D. and
Gerald Nissenbaum, M.D./Jersey City

A recent advance in gastrointestinal endoscopy has been the development of the fibergastroscope.[1,2,3,4] This new instrument uses glass fiber bundles instead of the lenses which conduct the image in the ordinary gastroscope. The fibergastroscope permits light to be conducted along a curved path. The light traverses each rod via a zigzag path, traveling always in straight lines and repeatedly bouncing off the surface of the glass fiber until received at the proximal eye piece. Each glass fiber, with a diameter of .006 inches, has a high index of refraction. It, in turn, is coated by another glass fiber of a low index of refraction, to diminish light loss by scatter. In the fibergastroscope† which we have been using, approximately 150,000 glass fibers are gathered together to make a fiber bundle unit of about ¼" diameter. This is easily swallowed by the patient. Light transmission through the fibergastroscope is 2½ times more efficient than it is through the standard gastroscope, providing sufficient illumination to take good color movies and still pictures with slight modification in the light intensity and color temperature.

A fibergastroscope (Fig. 1) includes a viewing end with an ocular, a focusing rim, a light connection, an air connection and the handle for focusing the objective. The shaft contains

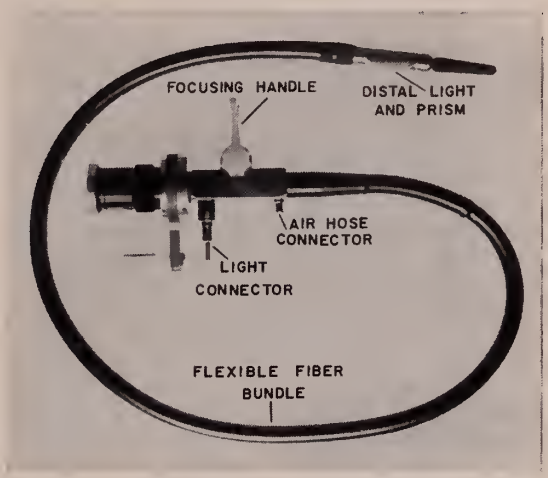


Figure 1. Fibergastroscope. Note the flexibility of the instrument. Inaccessible areas of the stomach, particularly the antrum and prepyloric region, can be visualized because of this flexibility.

the completely flexible fiber optic bundle unit which itself is enclosed by a waterproof covering. At the distal head is a lamp housing with adjacent prisms which focus the image on the end of the fiber bundle. A soft small rubber tip is provided at the most distal portion to insure ease of passage and provide insulation for the distal light. A standard 10 volt variable transformer serves as the power source. The overall length of the instrument is 38 inches, and the overall diameter is slightly less than a half inch.

Recently a cold light fibergastroscope has been

* Presented by Dr. Groisser at the Annual Meeting of The Medical Society of New Jersey, May 19, 1964.

† The Hirschowitz Gastroduodenal Fiberscope—manufactured by American Cystoscope Makers, Inc.

developed. A trifle smaller in diameter, this has a slightly smaller viewing area than the fibergastroscope described above. The viewing area is diminished, however, because of a secondary light-carrying fiber optic bundle which surrounds the viewing bundle and carries light from an outside high intensity source (a high intensity parabolic lamp in a power supply cabinet) into the stomach as a cold light (Fig. 2). Because of the distance travelled from the cold light source through a fiber optic cable which is attached to the fibergastroscope, there may be considerable light loss. The advantage of the cold light is the elimination of the regular incandescent light source within the stomach with its attendant heat when used over prolonged periods of time.

Clinical Application

During the past 3 years we have done fibergastroscopy on 373 patients at the Seton Hall College of Medicine, at the Jersey City Medical Center, and at Mountainside Hospital in Montclair. (See the tabulation below.)

FIBERGASTROSCOPIC FINDINGS IN 373 PATIENTS

Clinical Categories	No. of Patients
Hemorrhagic erosive gastritis	52
Antral gastritis	35
Atrophic gastritis	27
Hypertrophic gastritis	10
Giant polypoid gastritis	1
Radiation gastritis	2
Chronic gastric ulcer	47
Acute gastric ulcer	5
Stomal ulcer	5
Pyloric obstruction	2
Gastric carcinoma	27
Thrombocytopenic purpura	2
Hemagioma	1
Gastric polyp (single)	2
Gastric polyps (multiple)	1
Lymphoma	5
Leiomyosarcoma	2
Henoch-Schoenlein purpura	1
Foreign bodies	6
Normal gastrojejunostomy	21
Normal stomach	119
Total	373

The fibergastroscope was especially valuable for these reasons: (a) its flexibility has provided ease of passage and prolonged periods of observation, up to 90 minutes in some patients; (b) because of its flexibility, we have been able satisfactorily to view the antrum and pre-pyloric region of the stomach—areas frequently inaccessible to the standard gastroscope; (c) because of the flexibility of the fibergastroscope, we have been able to view regions of the pars media of cascade stomachs which (by reason of topographic distortion)



Figure 2. High intensity cold light source with cable attachment to fibergastroscope.

often prevent adequate passage of the standard gastroscope; (d) because of its flexibility, we have been able to perform endoscopic examinations of the stomach in patients with kyphoscoliosis; (e) because of its flexibility, we have been able to enter and study the proximal portion of the afferent and efferent limb of gastrojejunostomies; (f) because of the relative ease of passage, we have performed endoscopic examinations at the bedside when special circumstances prevented us from moving the patient to the endoscopy room; and (g) the excellent transmission of light by the fiber bundles has permitted the taking of 8 and 16 millimeter moving pictures. This provides an objective record of the lesion viewed by the gastroscopist. The record so obtained may be studied, and compared with other supporting information including x-ray, tissue specimens, exfoliative cytology, and surgical findings. The means by which direct reflex cameras may be attached to the fiberscope has been considerably improved by the development of a new rotating camera-scope bracket attachment (5) (Fig. 3).

Fibergastroscopy

Standard gastroscopy and fibergastroscopy are by no means reciprocally exclusive. Indeed, we prefer initially to use standard gastros-

copy in all patients, unless passage of the instrument is prevented by a physical deformity such as kyphoscoliosis. For short term use (less than 20 minutes), the patient tolerates the gastroscope as well, if not better than the fiberscope which is of larger diameter. Orientation is better with the gastroscope. Areas accessible to view with this instrument may be more easily reached and more readily evaluated. The tip of the gastroscope may be controlled. The fibergastroscope lacks

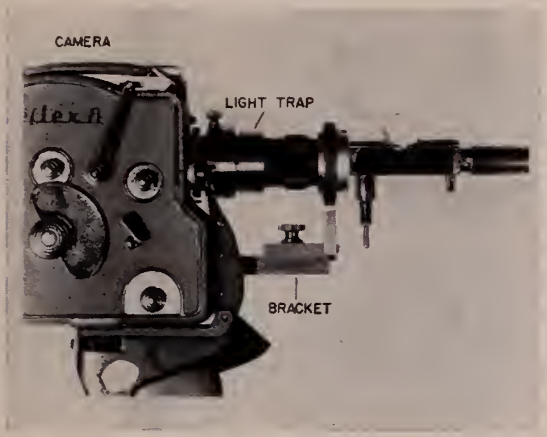


Figure 3. Direct reflex 8 camera (Camex®) with rotating bracket attachment to fibergastroscope, providing an excellent means of taking moving pictures within the stomach.

this. Viewing the posterior wall is better accomplished by the new standard gastroscope. We follow standard gastroscopy by fibergastroscopy in all patients in whom a lesion is inaccessible to the gastroscope, in patients with lesions requiring confirmation, in patients who are incompletely evaluated, and in all in whom we wish to photograph the lesion.

Standard Fibergastroscopy vs. Cold Light Fibergastroscopy

Cold light fibergastroscopy is still in its infancy. Although it does have the advantage of eliminating heat at the distal portion of the fibergastroscope, the smaller field provided by its objective is a distinct disadvantage both for diagnostic purposes and for taking pictures. Thus, we rely on "standard" fibergastroscopy at the moment. Further advances in cold light fibergastroscopy are anticipated. At the present, a cold light fibergastroscope is being developed with the same image size as the conventional fibergastroscope.

The Future of Fibergastroscopy

The most exciting advance which we can hope for in fibergastroscopy is the development of a fiber bundle flexible and narrow enough to pass into the duodenal bulb and into the second and third portions of the duodenum. Claims have been made about the ease of viewing the duodenal bulb by the present fibergastroscope. This, however, has not been the experience of most gastroenterologists, including ourselves. In only a few occasions have we been able to obtain a glimpse of the duodenal bulb mucosa with our presently available instrument.

The instrument will also be of additional value when a biopsy attachment is available and control of the distal tip by an outside guide is achieved. A potential great asset would be development of an infra red light source that would aid the study of mucosal blood vessels and blood flow and an ultraviolet light source for use in conjunction with tetracycline-induced fluorescence for study of carcinoma.

Summary

A new instrument, the fibergastroscope, has become available in the past few years. This further enhances the endoscopic evaluation of gastric lesions. Experience in 373 patients is recorded. Comparison is made with standard gastroscopy. These procedures supplement each other. The ability to take moving pictures through the fibergastroscope (cinefibergastroscopy) is a special feature which adds to the diagnostic, teaching, and research value of this instrument. Suggestions for future development of the diagnostic fibergastroscope are made.

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21 Plymouth Street (Dr. Grossier)

Seven out of 12 pathologists said it was malignant. But it wasn't.

Keratoacanthoma*

Albert Ehrlich, M.D.
Alfred Zitani, Jr., M.D.
Hoboken

Keratoacanthoma is a relatively common and clinically important skin neoplasm. It is a rapidly growing benign skin tumor which undergoes spontaneous involution[1] in 2 to 10 months. It presents a formidable problem because of its remarkable resemblance to squamous cell carcinoma of the skin.[2,3] Histologically, a keratoacanthoma frequently mimics squamous cell carcinoma. The clinical involution of the growth is the most reliable criterion of differentiation from a malignant neoplasm. Early correct diagnosis is essential for the best management of this lesion. Waiting for evolution to decide the true nature of the neoplasm is not the desirable method of diagnosis.[2,3]



FIGURE 1
Elevated firm keratoacanthoma—arose in six weeks after incision of small pustule on cheek.

A 45 year old woman with no unusual history of exposure to sun or chemicals noted a persistent 2 millimeter pustule in the mid-point of her left cheek. This was incised for drainage by Dr. M. De Bari. A circular elevated lesion grew centrifugally so rapidly that in 4 weeks she was presented with a circular elevated lesion 5 centimeters in diameter. The tumor on her left cheek was elevated by 2 centimeters, and had a rough friable pink to grey surface (Figure 1).

A small wedge biopsy was first considered to be a squamous cell carcinoma by the pathologist. When he saw the patient, however, and learned the history of extremely rapid growth, he considered keratoacanthoma as a more likely diagnosis. Doctors Hugh Grady, Arthur Allen, and James Graham concurred in the diagnosis of keratoacanthoma. Yet when the same slides were shown to twelve pathologists, seven were of the opinion that the tumor was a squamous cell carcinoma.

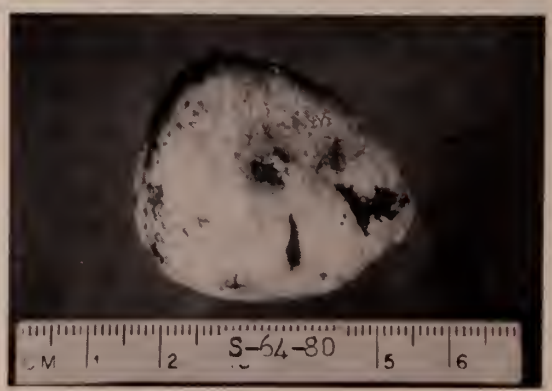


FIGURE 2
Excised skin lesion 4 x 3½ cm.

The lesion was reported as a keratoacanthoma. Six weeks after it was first noticed, it was completely excised. A sliding pedicle skin graft from the neck was placed on the wound site. The resected specimen measured 4 centimeters in diameter and was 1 centi-

* From the St. Mary Hospital, Hoboken, N. J. Dr. Ehrlich is the Director of Laboratories and Dr. Zitani is an Associate Attending in Surgery.



FIGURE 3

Gross section of excised specimen. Growth extends through entire dermis.

meter thick (Figures 2 & 3). Sections stained with hematoxylin and eosin showed numerous down-growing epithelial pegs extending through the dermis and invading the subcutis (Figures 3 & 4). High power magnification showed pseudoepitheliomatous hyperplasia and keratinization (Figure 5). The tumor recurred rapidly. Ten days after surgery, a neoplasm was seen in the line of incision even before sutures were removed (Figure 6). The patient was referred to Dr. Anthony Cipollaro of New York Medical College for medical management of the recurring lesion. She received 4 superficial radiation treatments as well as Aristocort® and methotrexate (triamcinolone diacetate).



FIGURE 4

Section of keratoacanthoma showing down growing epithelial pegs extending through dermis (X 14).

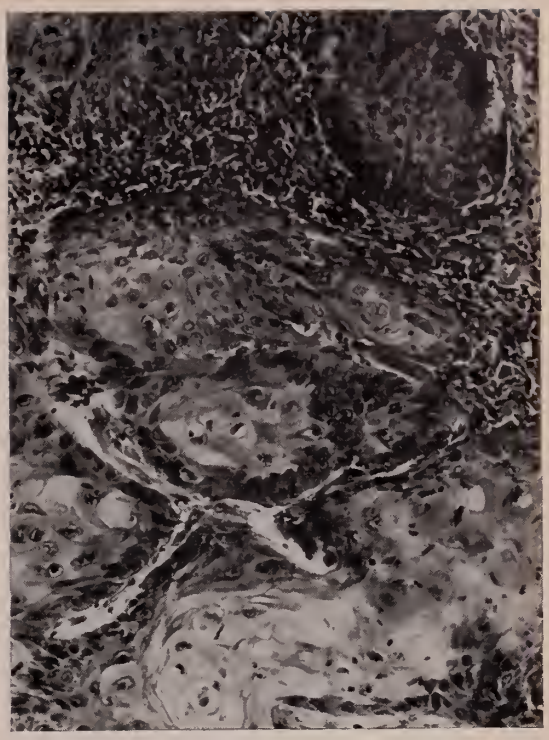


FIGURE 5

Section of keratoacanthoma with marked pseudoepithelimatous hyperplasia and keratinization (X 125).

Six months after initial surgery, or 8 months after the onset of the skin lesion, treatment with both tincture and ointment of podophyllum was used. Drastic improvement followed (Figure 7). At the end of one year from the onset, there was excellent healing with hardly a discernible scar (Figure 8).



FIGURE 6

Recurrence and spread of keratoacanthoma 4 weeks after surgical excision of tumor.

This case is reported because the lesion is much larger than the usual keratoacanthoma. Correct diagnosis by the pathologist guided the surgeon and aided the dermatologist.



FIGURE 7

Healing of lesion after surgical and medical treatment. Onset of keratoacanthoma 8 months.



FIGURE 8

Barely visible scar of excised and medically treated keratoacanthoma 1 year after onset.

Conclusion

1. A keratoacanthoma in a 45-year-old woman is presented.
2. Difficulty in pathologic diagnosis was encountered because of close resemblance to squamous cell carcinoma.
3. An excellent cosmetic result was obtained despite the large initial disfiguring face lesion.

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St. Mary Hospital

Dermatologists Elect

At its annual meeting on May 25, Dr. Henri Abel of Elizabeth was elected president and Dr. I. L. Maskins of Fairlawn, secretary, of the New Jersey Dermatological Association. Other officers elected at that meeting included Doctors Jean A. Cramer, William Cohen, Martin Wortzel, and Joseph Shapiro.

If the surgeon doesn't think of it, his patient may die of a fat embolism after apparently doing well following an injury.

Fat Embolism

A Case Report

John W. Bromley, M.D.
Philip Cohen, M.D. / **Paterson**

Fat embolism is an unusual condition occasionally associated with soft tissue trauma and fractures of long bones. The subtlety of the developing clinical picture causes difficulty in diagnosis and the patient may die before the correct diagnosis is made. Even postmortem examination may fail to reveal the true cause of death, unless fat embolism is searched for.

Two physiological mechanisms[1] are believed to be involved[2] in the production of this peculiar clinical illness.[3] The first is a mechanical obstruction of the pulmonary arterioles by abnormally large fat globules which appear in the circulating blood following trauma. The second mechanism is toxicity following hydrolysis of the abnormal fat globules and release of certain toxic fatty acids. The former mechanism is generally accepted;[4] the alternate hypothesis is still controversial.[7]

The pathologic process commences with the appearance of large (10 to 15 micron) neutral fat globules in the circulating blood. The source of these globules[5] is unknown. There is progressive obstruction of the pulmonary arteriolar system which may lead to *cor pulmonale,* shock, and death. The rate of appearance of these globules in the circulation largely determines the clinical course. If the right ventricle can compensate for the increased pulmonary pressure associated with the arteriolar obstruction, severe cardiorespiratory symptoms do not develop. The quantity of fat in the circulation determines the subsequent course. There may be absence of further clinical symptoms or the progressive development of neurologic manifestations. This may result from the hydrolysis of the neutral fat and the appearance of significant amounts of toxic fatty acids as advanced by Peltier.[3] Cobb,[7] however, believes this is the further result of brain arteriolar obstruction by fat globules.

Clinical Picture

The most serious syndrome is one which often occurs in the patient who has sustained multiple traumata. An initial early response to measures to combat shock is followed by progressive deterioration in the patient's cardiorespiratory function with shock, tachycardia, wheezing, râles, cyanosis, and death. The full cycle is run during the first 24 to 48 hours. The diagnosis can be established only by suspecting fat embolism and then conducting early urine examinations for fat. The presence of fat in the urine, together with this clinical picture, is sufficient for a presumptive diagnosis. Therapy should be started promptly.

The more common form of the disease is manifest 48 to 72 hours after injury. The patient has had a good initial response to therapy and this is followed by a gradual development of tachycardia, tachypnea, restlessness, and convulsions, leading eventually to coma. The urine for fat is usually positive. There is a progressive fall in hemoglobin values despite the absence of new blood loss. Petechial hemorrhages, especially about the shoulders and face, may be present. Obstruction of retinal arterioles by fat globules and retinal hemorrhages may be detected on funduscopic examination. The chest x-ray often reveals the classic "snowstorm" appearance.

The symptoms usually progress until about the eighth day after the injury. Then either death or spontaneous resolution occurs. With resolution, there is a rapid return of vital signs to normal. The neurologic symptoms abate and there is a spontaneous elevation of the depressed hemoglobin values. Recovery is usually complete.

Prevention, by gentle handling of injured parts and early immobilization of fractures, is basic.

Treatment is mainly supportive and is aimed at combating shock and respiratory difficulty. Blood transfusion, oxygen and, occasionally, digitalis may be necessary. Specific measures to combat arteriolar obstruction are limited to the intravenous administration of alcohol (usually 5 per cent alcohol in dextrose) 500 to 1000 cubic centimeters daily. This is believed to aid in the dissolution of the large fat globules. Heparin has also been advocated. No adequately controlled series of cases has been reported to substantiate claims for the efficacy of either alcohol or heparin. It would seem reasonable, however, to add intravenous alcohol to the supportive regime for possible benefit until the syndrome is better understood.

A rather striking case of fat embolism was encountered by the authors at St. Joseph's Hospital and is reported below.

A 20-year-old Air Force man was admitted with a history of injuries to the left lower extremity in a motorcycle collision. He sustained no injuries other than to the left lower extremity. There was no history of head injury or unconsciousness. In the emergency room, his pulse was 88 and his blood pressure was 120/70.

He complained of pain in the left hip and ankle. He had several large lacerations over the antero-medial aspect of the lower leg and ankle. There was angulation of the leg in its distal third. The bone was exposed. Dorsalis pedis and posterior tibial pulses were absent and the foot was cold. He had a large hematoma of the proximal left thigh and pain and crepitation on attempted movements of the left hip.

X-rays revealed: (1) A comminuted fracture of the proximal femoral shaft with angulation (Figure 1); and (2) Extensively comminuted fractures of the distal left tibia and fibula, with a large defect due to bone loss (Figure 2).

The ambulance attendant brought in a 2 inch fragment of tibia which had been found on the ground at the site of the accident.



FIGURE 1

AP view left femur.

An initial hemoglobin was 12.4 grams and the hematocrit was 41 per cent. Under general anesthesia, the wounds were debrided and the anterior and posterior tibial arteries explored through the existing wounds. They were intact but in spasm. Following exposure, the spasm relaxed and the pulses became palpable



FIGURE 2

AP view left tibia (Pre-operative).



FIGURE 3

AP view left tibia (post-operative).

distally. The 2-inch segment of tibia found at the accident was thoroughly scrubbed and autoclaved for three minutes. It was carefully placed into the corresponding defect at the fracture site. The wounds were closed loosely with drains. Pins were placed through the os calcis and through the tibial tubercle, and the patient was placed on a Bohler frame with traction through the two pins. X-rays revealed acceptable position of the fractures (Figure 3 and 4).



FIGURE 4

Lateral view left tibia (Post-operative).

Post-operatively, he received prophylactic penicillin and dehydrostreptomycin. In addition, he received tetanus antitoxin and polyvalent gas gangrene antiserum.

The first post-operative day was unremarkable. But that night he was responding poorly. Next morning, he was unresponsive to all but strong stimuli. Now his temperature was 101. Blood pressure was 110/70; pulse was 100. Funduscopic examination was negative. Neurologic examination revealed hyperreflexia and a positive Babinski in the right leg. The neck was supple.



FIGURE 5

PA view chest.

There were no petechial hemorrhages. Spinal fluid pressure was 150. Spinal fluid analysis was negative. The neurosurgical consultant confirmed the impression of a traumatic fat embolism. Urine for fat was positive.

He was given nasal oxygen and intravenous fluids. He continued to be unresponsive throughout the day. On the third post-operative day, he had some spontaneous movement of the extremities but remained verbally unresponsive.

Chest x-ray revealed diffuse mottling throughout both lung fields (Figure 5). He received 1000 cubic centimeters of five per cent alcohol and water intravenously. The nasal oxygen was continued.

On the fourth postoperative day, he was more responsive and began to speak and obey instructions. He received an additional 500 cubic centimeters of five per cent alcohol and water. Hyperreflexia and Babinski persisted. He made progressive improvement. By the seventh postoperative day, he had regained normal mentation. The fractures were maintained in acceptable position and the wounds healed well. On the 47th postoperative day, he was placed in a hip spica incorporating the traction pins in the plaster (Figures 6 and 7). He was then discharged to a military hospital.

The accompanying graph illustrates more clearly the course with respect to temperature, hemoglobin, urine for fat, and the neurologic picture (Figure 8).



FIGURE 6
AP view left tibia.

The urine was positive for fat throughout this period and remained so for approximately three weeks.

A post-operative temperature elevation of 102 to 103 degrees dramatically returned to normal on the seventh post-operative day and corresponded to his clinical improvement.

At no time was shock a problem nor did the patient develop frank heart failure.



FIGURE 7
Lateral view left tibia.

The hemoglobin on admission was 12.5 Grams. He received 1000 cubic centimeters of whole blood at surgery. On the third postoperative day, it had fallen to 8 Grams. The decline continued: by the fifth day, the hemoglobin was down to 5 Grams. At this point, he was given 500 cubic centimeters of whole blood, which was repeated the following day. Then the hemoglobin rose to 9 Grams and the clinical picture improved.

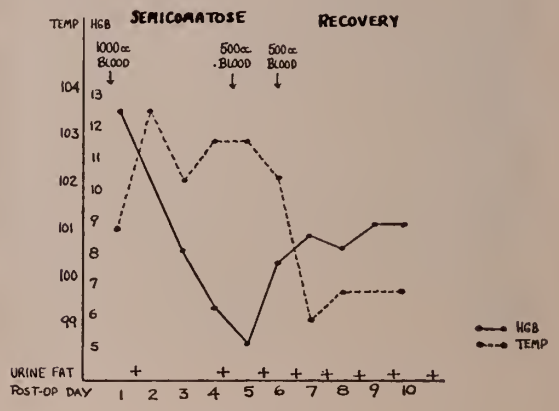


FIGURE 8

Follow-up evaluation a year later showed that the fractured femur had healed satisfactorily. A long leg plaster was maintained on the (left) leg and although position of the bone fragments remained satisfactory, bony union had not occurred. Eighteen months after injury the left tibia had healed without requiring further therapy.

Summary

An unusual case of fat embolism resulting in severe neurologic symptoms has been presented. Conservative management effected a remission. A brief discussion of theoretical pathogenesis is included.

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588 East 27th Street (Dr. Bromley)

Sympathetic ophthalmitis is a benign-sounding but potentially frightful complication; just as a table fork is a homey-sounding but potentially dangerous instrument.

Table Fork Eye Injury

George B. Sharbaugh, M.D.
Thomas K. Rathmell, M.D. / Trenton

An eleven-year-old boy, was hospitalized with a history of having injured his right eye with a table fork. He and a friend were washing dishes. While he had a fork in his right hand, his companion was pulling on his right forearm. When his friend suddenly relaxed his grip, the flexion of his muscles caused the prongs of the fork to pierce his right globe. This accident occurred at 9 A.M., but the boy was not brought to a physician's office until 7 P.M. He was hospitalized at 9 P.M.

He was a well-developed, well-nourished lad in obvious distress with pain in the right orbit. Examination of the right eye revealed two penetrating injuries: one at approximately seven o'clock in the area of the iris root, and one involving the pupillary area and pupillary margin of the iris with the iris included in the wound. The anterior chamber was fairly deep, and the corneal wound was not bulging. Vision was limited to counting the fingers in the temporal field. The conjunctiva of the left eyeball was injected and marked lacrimation was present. Photophobia was prominent. Ear, nose, and throat examination was negative. There were no palpable cervical lymph nodes. Cardiopulmonary examination was negative. The pulse was 80 and regular. His blood pressure was 120/80.

Laboratory studies showed a normal urinalysis, hemoglobin, red blood cell count, and color index. The white blood cell count was 14,000 with 82 per cent granulocytes.

Diagnosis was a penetrating injury of the cornea of the right eye with a prolapse of the iris and possible ciliary body and lens injury. Therapy consisted of tetanus toxoid, with cycloplegics, topical and systematic steroids, and antibiotics.

Prednisolone was given in a dosage of 10 milligrams daily, tetracycline (500 milligrams daily), topical chloromycetin with hydrocortisone, and atropine sulfate.

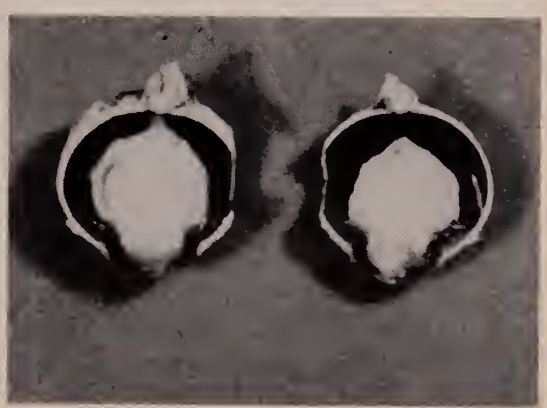
The condition of the injured eye progressively became worse. The globe became very red and the cornea appeared hazy. The nasal corneal wound developed a prolapse of the iris. The anterior chamber became shallow. No light perception was demonstrable.

A diagnosis now was panophthalmitis, secondary to the penetrating injury of the cornea plus a traumatic cataract which had developed as a result of the lens injury.

After 23 days' observation, and upon consultation with Dr. Levon Yazujian and Dr. Robert Murto, it was decided to enucleate the right eye. This was done to avert a sympathetic ophthalmitis, since there was no chance for vision in the injured eye.

Study of the globe in the Department of Pathology showed it to have an anterio-posterior measurement of 29 millimeters and an equatorial diameter of 28 millimeters. An area of ulceration was seen in the cornea in the upper outer quadrant (according to the insertion of the obliquus muscle). This was covered by proliferating tissue. The optic nerve appeared uninvolved.

The globe on section showed a yellowish-white vitreous measuring 20 by 10 millimeters which spread from the iris into the posterior chamber and displaced the crystalline lens into the anterior chamber. The retinal layer was uninvolved. A slender adhesion spread from the posterior pole to the fovea.



Globe showing vitreous abscess.

Histologic examination showed an intense purulent reaction throughout the vitreous; the choroid was uninvolved. Corneal ulceration with prolapse of the lens into the anterior chamber was noted. The purulent reaction involved the retina; there was hemorrhage and edema about the ciliary body, with evidence of newformed capillaries throughout the vitreous.

Pathologic diagnosis was panophthalmitis with acute abscess formation in the vitreous.

The cause of sympathetic ophthalmitis is unknown. Some type of allergic phenomenon is regarded as most likely. It occurs in three to four per cent of traumatic eye injuries. The

initial signs of sympathetic ophthalmitis in this patient were a haziness of the anterior chamber and small deposits on the posterior surface of the cornea seen by slit lamp examination. A draining wick was not placed in the puncture wound because of the dangers of infection. Secondary glaucoma might have resulted from such therapy. Conservative treatment is, generally speaking, used in this type of case until the chances for vision can be assessed. A traumatic cataract will develop if the lens capsule is punctured. The possibility of introducing an antibiotic solution into the vitreous to combat infection was mentioned, but this procedure was not used because of the danger of a local reaction and the demonstrable lack of an effect. The anatomic character of the vitreous is of some moment in that its consistency varies from a solid gel in youth to a near liquid in older individuals. The patient returned home after 30 days of hospitalization.

The Mercer Hospital (Dr. Rathmell)

Industrial Medicine Today

For every 507 industrial employees, there is one full-time medical employee. So says the Industrial Medical Association, reporting on a 1965 survey of 585 organizations. The term "medical employee" includes physicians, nurses, technicians, clerical and administrative personnel in the medical departments. These 585 organizations employed almost 4 million people.

The total number of full-time physicians in the programs covered in the survey is 951. When the number of hours of service performed by part-time physicians, on-call physicians, and specialists are equated to represent an equivalent number of full-time physicians, the total is 1,465. Each full-time physician serves an average of 2,487 employed persons. They are backed up by 5,344 occasional consultants. There are 3,804 full-time nurses. In addition, these plants had 727 full-time laboratory and x-ray technicians; 1,462 clerical personnel and 186 administrative assistants in medical programs. The plants provided diagnostic services which included: x-ray, electrocardiogram, urinalysis, hemoglobin determination, auditory testing, vision testing, blood chemistry, blood count, and pelvic examinations. Larger plants generally have more extensive activities in all of these areas; most of the services are done for the smaller companies on a "referred out" basis.

Pre-placement examinations are done at 95 per cent of the plants reporting. Examinations of employees returning to work following illness are performed at 84 percent of the plants. Disease follow-up examinations are conducted at 59 percent of the plants. Periodic appraisals are conducted on all employees by half of the plants. The larger the facility, the more frequently are examinations done on some special basis rather than routinely.

Some 58 per cent of the plant medical departments do not give such treatment at all; an additional 27 per cent treat only at the request of the employee's own physician. The remaining 15 per cent indicated that treatment is provided at the employee's request. Almost all of the medical directors reported that they maintain contact with the employee's physician during non-occupational illness.

Executive health examinations are provided by 88 per cent. These examinations are most frequently conducted in the plant medical department although smaller plants frequently refer this to outside sources.

Copies of the full report are available from the Industrial Medical Association, 55 East Washington Street, Chicago, Illinois 60602. Requests should be accompanied by 25¢ in stamps to cover the cost of the mailing.

A recently available drug, diazepam, seems to have been truly life-saving in this case of tetanus complicated by diabetes and a cerebral thrombosis.

Control of Tetanic Spasms With Diazepam*

Case Report of Severe Tetanus†

Joseph Moriarty, M.D./Passaic
Louis Bertolotti, M.D./Clifton

Tetanus is a rare disease in this country: only some 500 cases are reported annually. It has been estimated[1] that five times that number may be unreported, misdiagnosed, or otherwise missed. Of greater significance than the low incidence is the high mortality, ranging from 90 to 100 per cent of untreated cases[1] to 27 per cent under optimal management.[2] Though active immunization ensures protection, it is not universally practiced. Except for children and military personnel (who have been given tetanus toxoid) there is always the possibility that tetanus bacilli may invade any open wound, however slight.

Early recognition and swift, intensive therapy may be crucial to survival of a tetanus invasion. To illustrate this, we present here the report of the successful management of a case in which serious complications justified a poor prognosis. In the severe disease, the foreseeable complications include secondary infections such as pneumonia, atelectasis, pulmonary edema, urinary retention,[2] action of the neurotoxin on the centers which control respiration and circulation; myocardial damage,[3] and the iatrogenic sequelae of nervous system depressants, curare and curare-like compounds, and other drugs used in the treatment of the tetanus patient.

The therapeutic regimen for tetanus is now largely established: administration of tetanus antitoxin, antibiotics, debridement, and cleansing of the wound. Tracheostomy must be considered in the severely ill sufferer. A major requisite is the protection of the characteristically hypersensitive patient from tetanic spasms. The drugs so far used for this purpose—barbiturates, mephenesin, methocarbamol, meprobamate, and chlorpromazine—have only limited effectiveness. Oversedation is often a problem, especially if the respiratory center is already damaged by toxin or by the anoxia due to spasms or respiratory infection.[3] Neuromuscular blocking agents of the curare type used to control spasms involve the risk of respiratory paralysis which cannot always be avoided.

The chemotherapy of tetanus still lacks an effective agent of the ideal type described by Laurence and Webster[3] as able "to control convulsions and reduce spasticity without impairing respiration, voluntary movement, or consciousness."

In addition to other measures described in the case below, we administered diazepam,* a

* Product of Hoffmann-La Roche Inc., Nutley, New Jersey, tradenamed as Valium.

† From St. Mary's Hospital, in Passaic.

benzodiazepine derivative with potent antispasmodic properties in animals[4] and in clinical neurospastic[6,7] disorders.[5] Its successful use in tetanus has been described in two separate cases in the United States,[8,9] and in 4 children in Uruguay.[10]

A woman of 64 was first seen in the office, because of a "sore throat." She could not move her jaw, and had pain on swallowing. Ten days previously she had received a splinter wound in her right hand, which had been inadequately treated at home. For seven years, she had suffered from a mild diabetes, controlled by diet. Her father and two sisters had died from cardiovascular disease.

Physical examination showed no abnormalities except for stiffness of the jaw and neck joint, and the presence of trismus. Tetanus was suspected, and the woman was immediately hospitalized and given (after a test dose) 10,000 units of tetanus antitoxin intravenously, phenobarbital intramuscularly, and penicillin 5 million units.

Tetanic symptoms developed with great rapidity. Tracheostomy was done, and the wound abrided. Subsequent events are presented in the table, which outlines the measures used as the primary infection and severe complications developed.

By the afternoon of day 2, when the patient was having tetanic spasms, diazepam* became available, and was used continuously thereafter for the control of these symptoms until the ninth hospital day. The drug was then discontinued because there had been no spasms for the 48 previous hours. It was resumed two days later when the spasms returned. Dosage of diazepam started at 5 milligrams by slow intravenous administration (two minutes) every 4 hours, and ranged up to twice that dosage. Laboratory tests revealed no ill effects attributable to the drug.

The patient received massive doses of antitoxin and penicillin or achromycin, and insulin for the control of her diabetes. During the crises of two cerebral vascular accidents and bronchopneumonia she was also administered meralluride (Mercuhydrin®). For the first two weeks a Ventalung® respirator was necessary; and on occasion, a hypothermia machine and oxygen tent. Despite the gravity of bronchopneumonia superimposed on the arteriosclerotic heart condition and a hemiplegia which followed the second stroke, the patient made a good recovery by the sixth week in the hospital, and remained well after discharge.

Considering the age of the patient, her diabetic condition with its threat of acidosis, and the grave complications which developed in the cardiovascular and respiratory systems—all superimposed upon a rapidly progressing tetanus infection—the prognosis was poor. Diazepam* was a crucial factor in her survival.

As a muscle relaxant this agent proved ideal in this case since it reduced (and even inhibited) tetanic spasm and still left the patient sedated but easily aroused and easily handled so as to obviate the usual low-threshold response to sensory stimulation. This reduction of spasm is of prime importance in the tetanus patient because it prevents anoxia to the cerebral centers. Although the Ventalung® respirator was used at the first signs of respiratory embarrassment, the inhibition of spasms kept the patient relatively free of anoxic episodes. Toward the end of the four-hour period between diazepam* doses, the spasms tended to recur; and the return of these symptoms when diazepam was discontinued for two days plainly revealed the control it exerted.

The exact mechanism of this control is not known. Diazepam* seems to act on the ventral horn cells at the interneuronal junctions in the spinal cord. The toxin is known to act on the central neurons. The descending course of the spasticity from the muscles of the face to the lower extremities is believed to follow the spread of toxin along the cerebrospinal axis.[3] In our patient these toxic effects were limited to the neck and back muscles. This suggests a blocking of this spread down the cord by diazepam.* This is conjecture, but we feel no doubt that diazepam* exerts a specific suppressant action on tetanic spasms which makes it the drug of choice in the management of this aspect of a dangerous infection.

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Day	*Antibiotic*	*Intravenous Diazepam*	*Other Medication*	*Condition of Patient; Measures Used*
	Penicillin 5 million u	slowly intravenously		
1	Penicillin	none	Phenobarbital	Trismus on admission, rapidly developing symptoms, opisthotonos, tracheostomy, abridement of wound.
2	Penicillin	5 + 5 mgm	Phenobarbital meperidine insulin Methocarbamol	Respirator ordered. Patient had convulsion, was cyanotic. Diazepam became available later in day. Insulin dose determined by urine glucose levels.
3	Penicillin	5 mgm q.4.h.	Insulin	
4	Penicillin	7.5 mgm q.4.h.	Insulin	Patient cyanotic, brief tetanic spasms. By now has received 200,000 units tetanus antitoxin.
5	Penicillin	7.5 mgm q.4.h.	Insulin	
6	Penicillin	10 mgm q.4.h.	Insulin	Short tetanic spasms, occasional cyanosis
7	Penicillin	10 mgm q.4.h.	Meralluride and deslanoside	Profuse bronchial secretions, moist rales, some spasms—chest x-ray showed mild cardiac dilatation, and congestive changes in both lungs. No tetanic spasms.
8	Penicillin	7.5 mgm q.6.h.	Deslanoside and Meralluride	Lungs dry, color good. No tetanic spasms.
9	Penicillin	none	Insulin	Diazepam discontinued—no spasms for 48 hrs. In p.m. patient stuporous; temp. 102 F., x-ray showed arteriosclerotic c.v.—disease; bronchopneumonia.
10	Achromycin	none	Meralluride	ERG indicated myocardial ischemia.
11	Achromycin	7.5 mgm q.6.h.	Insulin	Tetanic spasms returned, diazepan resumed.
12	Achromycin	7.5 mgm q.6.h.	Insulin	Patient better. No spasms, ronchi or rales. Tracheostomy tube removed.
13	Achromycin	7.5 mgm q.6.h.	Reduced insulin dosage	Patient's color and condition better. She can now dangle feet. No spasms.
14	Achromycin	5 mgm (p.o.) q.4.h.	none	All intravenous tubing discontinued. Fluids (by mouth) forced.
15	Achromycin	none	Meralluride	Patient suffered right hemiplegia from sudden stroke. Comatose. Hypothermia. Hourly suctioning of pharynx necessary.

During following week the patient improved; the hypothermia machine and oxygen tent were removed. Patient recovered slight movement of the right arm, but was still unable to speak. On day 23 a second CVA occurred; on day 26 a repetition of episodes of dyspnea. But improvement continued. 6 weeks after admission the patient was discharged as recovered. She was still well a month later.

54 Grove Street (Dr. Bertolotti)

In spite of inflation, the dollar still has purchasing value—if you have the ingenuity to use it well. Here is one way.

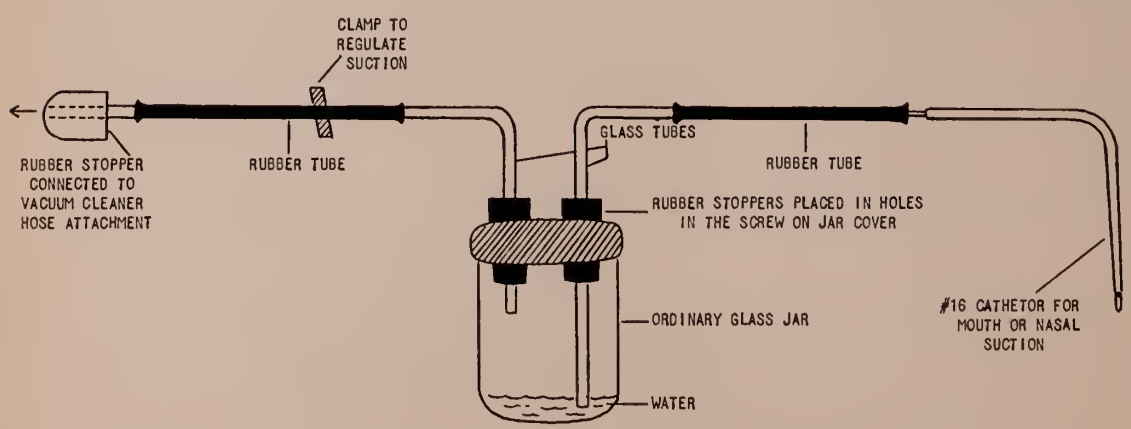
A Simple and Inexpensive Suction Apparatus For The Home

Murray Strober, M.D.
Melvin Weinhouse, M.D. / **Nutley**

With the population aging, there is a greater need for simple, effective, inexpensive, medical equipment that can be made readily available for home use.

Recently, as practicing physicians, we encountered a very efficient and economical home suction device. The device was conceived by a devoted son for his invalided, elderly mother. The incapacitated patient was greatly distressed by retained, mucoid, bronchial secretions.

The apparatus was hooked up to an ordinary home vacuum cleaner. Since most homes already have vacuum cleaners, the total cost of the additional parts required was under one dollar. The catheter can be readily detached, cleaned, and sterilized. Suction was simply maintained by running the vacuum cleaner. This suction equipment worked quite as well as elaborate and expensive hospital devices. We recommend this apparatus for any patient treated at home who is troubled by retained salivary or bronchial secretions.



3 Cathedral Avenue

Men are apparently as prone to cheat on their diets as women—and for cardiac men, they may find themselves dying for one more snack.

Failures in Controlling The Weight of Cardiacs*

Anne B. Caldwell, Ph.D./Montclair

Varying factors account for failure in a weight-reduction program with cardiac patients. Presumably, the obese patient who has experienced a heart attack should be more greatly motivated to correct or avoid obesity than others.

Berryman et al.[1] reported on weight reduction of patients with coronary artery disease. All were initially successful in losing weight, but at the end of two to three years, half of them had not sustained the loss. *Simon et al.*[2] reported that he had not elicited the hoped-for fuller cooperation of cardiovascular dieters. The greater motivation was seemingly not enough to separate the performance of this group from that of the "just fat, otherwise healthy."

Multiple etiologic factors as well as pathophysiologic and psychologic disturbances may be involved.[3] To delineate which of these factors was of major importance in failure of weight control in patients of the Atherosclerosis Research Project, the following study was undertaken.

Twenty-four men between the ages of 20 and 50 years with proved myocardial infarction, needing weight reduction, were studied as "failures" or "drop-outs." They were part of the special research project initiated by the Heart Program of the New Jersey Department of Health, whose background and aims were previously reported.[4] Of the original group of 150 men, these 24 were the only members who refused to continue further participation in the program.

The methods of establishing standards for weight and diet have been published previously.[5] Briefly, 1200 calorie diets containing 25 per cent protein, 30 per cent fat, 45 per cent carbohydrate, and vitamins and minerals to meet the recommended allowance of the National Research Council, were prescribed. If carefully followed, the diet would allow a weight loss of about two pounds weekly. However 8 ounces a week on a continuing scale was an acceptable minimum.

All members of the professional staff were themselves svelte and trim. The personal approach, with close supervision by the project physician and nutritionist, was used. The patients' "diet prescription" was not an impersonal printed dietary form. It was individually hand-tailored and carefully presented. Weight checks and consultations with the nutritionist were frequent. Supplementary investigational tools were the Cornell Medical Index, medical interview and examination, nutrition questionnaire, and nutrition interview. Reaching ideal weight was a prerequisite for placement in the overall research program.

Results

Of the 24 drop-outs, 11 men participated in the project less than 26 weeks and 13 partici-

* Co-authors of this paper are: Portia B. Watson, M.S.; Veronica M. Mollek, M.A.; Donald P. Green, M.D.; Alvin Florin, M.D.; and Marvin L. Bierenbaum, M.D. This work comes from the Atherosclerosis Research Group of St. Vincent's Hospital, Montclair. It was supported in part by Public Health Service Research Grant H-5905, from the National Heart Institute, and in part by Grant-in-Aid No. F26, from the New Jersey State Department of Health.

pated more than 26 weeks, with a median of 31 weeks. The range was 5 to 162 weeks.

Among these 24 failures, those needing to lose the most weight were the least successful. Four men needing to lose 10 to 40 pounds all gained weight.

TABLE I

Weight Loss Performance of Drop-outs Compared to That of Successful Weight Losers

Patient Group	Weight Loss Desired	Number of Cases	Average % Weight Loss of Total Desired	Range of Achievement
Drop-outs	less than 19 lb.	6	33	0–83%
Successes		35	100	
Drop outs	20–39 lb.	10	26	0–66%
Successes		7	100	
Drop-outs	over 40 lb.	4	5	0–11%
Successes		2	100	

Table I compares the weight loss, as percent achievement, of this group of 20 patients who dropped out with that of a matched group of 44 successful dieters of the same research group who were previously reported.[5]

Of the 24 failures, 4 gained weight, 7 lost less than 10 per cent of weight loss desired, 10 lost from 10 to 50 per cent of weight loss desired, and only 3 lost more than 50 per cent of weight loss desired.

Smoking habits of the successes and drop-outs are compared in Table II.

TABLE II

Smoking Habits of Drop-outs Compared to Those of Successful Weight Losers

Patient Group	Heavy Smokers* B‡	A	Moderate Smokers B	A	Non-Smokers B	A
Drop-outs	66%	(0%)	17%	(33%)	17%	(67%)
Successes	11%	(11%)	57%	(25%)	32%	(64%)

*Heavy smokers = 20 or more cigarettes per day; moderate smokers = less than 20 cigarettes per day
‡B = before coronary attack; A = after coronary (figures in parenthesis)

Alcohol consumption tended to be about the same in the successes and failures groups. About half of the subjects in each group drank varying amounts of alcoholic beverages prior to admission. The successful dieters were able to eliminate, or sufficiently moderate, their alcohol intake to achieve their weight losses.

Eating habits of the successes and drop-outs are compared in Table III. Some patients checked several habits.

TABLE III

Eating Habits of Drop-outs Compared with Those of Successful Weight Losers

Patient Group	Snackers, Nibblers	Fast Eaters	Irregular Meal Times	Overeating when Overtired
Drop-outs	71%	67%	38%	33%
Successes	20%	50%	16%	23%

Emotional symptoms reported by the successes and drop-outs are noted in Table IV. Some patients reported multiple symptoms. Of the successes, 10 ignored these questions.

TABLE IV

Emotional Symptoms Reported by Drop-outs and Successful Weight Losers

Patient Group	Nervous	Sensitive	Depressed, Unhappy	Impulsive
Drop-outs	29%	54%	29%	17%
Successes	56%	56%	17%	12%

Exercise as a factor in controlling weight was evaluated by questionnaire and occupation analysis. Of the failures, approximately two-thirds were passive or in the passive occupations before the attack and after, as compared with one-third of the successful dieters.

Discussion

Stunkard and McLaren-Hume,[6] in reviewing weight-control programs over the previous 33 years, had found results generally poor. This project's extraordinary high ratio successes, as followed for a period of four years, should be attributed to the following:

(a) We were working with a highly motivated group threatened with a lessened life expectancy, as evidenced by the unfavorable mortality statistics for obesity in males.

(b) The trimness of the staff members encouraged the patients to achieve satisfactory weight reduction. Tullis[7] observed that it was incongruous for the physician or nutritionist to be flabby with fat as he or she outlined a reducing diet.

The failure in 24 patients may be attributed to the following:

(a) *Cessation of smoking.* Eighty-three percent of the failures were trying to control smoking. Of the successes, only 36 per cent were trying to give up smoking. Of the non smokers, half were ex-smokers who had been such light, casual smokers prior to the heart attack that giving up smoking had been no problem. Many smokers who desist find themselves snacking between meals and tend to gain weight. The cessation of smoking as a cause of weight gain over a two-year period has been reported by Brozek and Keys.[8]

(b) *Alcohol consumption.* While many studies either ignore the role of alcohol consumption in human obesity, or mention it as of no great importance, Mendelson *et al.*[9] found that alcohol accounted for a significant proportion of the caloric intake of half of the subjects, and that it seemed to increase food intake in some. Yudkin[10] found that business and social drinking (and usually a secondary concomitant rise in food consumption) are major factors in the failure to lose weight or to maintain weight after successful reduction. For many of the patients in this project, alcohol is a calorie problem in successful weight reduction. Half of this group drank alcohol daily. Two consumed one-third to one-half of their daily caloric needs as alcohol. These two were not considered "alcoholics," since drink did not interfere with their job performance or daily life. One of these further increased his caloric intake by taking all of his alcohol in the form of sweet drinks. Weight reduction in this situation became a discouraging process.

(c) *Eating patterns.* With the obese, eating patterns may be of importance in a weight-reduction program. The pattern of three meals a day, with or without coffee or snack breaks, with the large meal usually in the evening, is a typical one. Gordon *et al.*[11] reported on success in weight loss and maintenance up to periods of six months, using a plan of a 48-hour fast followed by a six-meal day. Their diet was high in protein (30 per cent) and fat (55 per cent), and low in carbohydrate (15 per cent). The calorie level was 1320, close to the 1200 calorie level used with this group. Two-thirds of our failures were on regular 3-meal per day patterns, but 71 per cent also admitted being nibblers, compared with 20 per cent of the successes. "Nibbling" represents a way of eating quite different from Gordon's definite 6-meal pattern. It may be that a 6-meal pattern would discourage nibbling of extra, unneeded calories.

(d) *Emotional problems.* Emotional problems appear to be definitely related to food intake, but are difficult to assess in a quantitative measure. In filling out questionnaires relating to anxiety and emotional stress, many patients conceal true feelings. Sometimes these feelings may be brought out at the medical or nutritional interview. One of the failure patients who answered "no" to all questions relating to emotional stress consistently gained weight and, just as consistently, reported an 800 calorie intake, with anorexia at breakfast and a light food intake during the day. Stunkard *et al.*[12] reported on a group of patients who under-estimated daily calories and repressed mention of calories eaten at night. Bruch[13] stated that this may be associated with early feeding problems, eating as defiance, and the unconscious reasoning that "food eaten after dark does not count." Some such factor must function to render understandable reports of food intakes of 800 to 1200 calories by patients who continue to gain weight. This amount may be all they do eat—during the day.

(e) *Physical activity.* Exercise may play an important role in controlling weight, but it is difficult to assess. In this group of failures, the majority were "passive" in regard to exercise and occupation. This was the reverse of the successful group of dieters, of whom two-thirds were "active" in regard to exercise and occupation. This would be reconcilable with the concept of the need to maintain physical fitness, as championed by White,[14] who found less coronary heart disease in athletes who maintained vigorous physical activity into middle age. This concept would appear to be contradicted by Spain et al.,[15] who, in a prevalence study, did not find overweight per se an important contributing factor in the development of coronary atherosclerotic heart disease—relative muscle mass, rather than increase in adipose tissue, had a more direct association.

(f) *Angina.* Frequent anginal pain would appear to be a factor motivating successful weight loss, for 18 of 24 failures reported very little or no anginal pain, as compared to an incidence of angina in the successful dieters of 75 per cent. Interestingly enough, there have been 5 deaths in this group of 24 since they dropped out of the project, as compared to the expected one to two deaths, if they had remained in the larger group of successes.

Summary

Some factors were enumerated in 24 failures in a weight-control program, involving 150 men with previous myocardial infarction. The factors that operated to prevent success were: deliberate misrepresentation or self-deception in calorie consumption; cessation of smoking, resulting in more frequent nibbling; moderate to high alcohol consumption in half the group; increased food consumption in relation to various pressures, personal and business; and absence of frequent anginal pain in three-fourths of the group. No one factor can be definitely assigned as the major agent. A multiplicity of elements appears to play a complicated role.

A list of 15 citations appears in the author's reprints.

48 Plymouth Street

STATE ACTIVITIES

Trustees' Minutes

May 14, 1965

The final Board meeting for 1964-65 was held in Atlantic City on the evening of May 14 at Haddon Hall. For the further information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Senate Bill 150 . . . Reconsidered—at the request of the Council on Legislation—its previous position of "no action." Voted, now, to approve S-150—the State Health Aid Bill.

Current State Legislation . . . Considered the following bills and, on recommendation of the Council on Legislation, adopted the official positions indicated.

All bills thus marked (*) are identical with measures of last year—or preceding years—whose positions were the same.

S-69 —To require all motor vehicles—other than
A-137—diesel-powered—motorcycles, and electric vehicles to be equipped with crankcase ventilating systems of a type approved by the Air Pollution Control Commission. *Disapproval* . . . because there is no provision for inspection or enforcement of the law by means of a supervisory or responsible body.

S-143—To establish a State Public Sanitary Sewerage Facilities Assistance Act of 1965. *Approval*

S-195—To forbid the suspension of any sentences for the illegal manufacture or sale of narcotic drugs. *Approval*

S-196—To provide a prison term of not less than 20 years for hiring or use of any child under 18 years of age in illegal sales or transactions of certain narcotic drugs. *Approval*

S-197—To increase the penalties of certain narcotics violations and to forbid suspension of sentences. *Approval*

S-218—To permit appointment of any physician licensed and employed as a health officer by a municipality to a board of managers of county hospitals, notwithstanding he is not a citizen of the county. *No Action*

S-227—To require pupils and teachers to use eye protective devices while attending classes in vocation or industrial art shops or laboratories where processes are taught which may cause damage to the eyes. *Approval*

In considering this legislation, the council noted the following recommendation approved by the Board of Trustees at its February 24 meeting and referred to the Special Committee on Child Health:

That MSNJ investigate and select the proper means to effect the adoption and use of goggles or protective eye glasses by students in school situations that might endanger their eyes if unprotected.

S-230—To provide that no motor vehicle shall be
A-587—registered unless it complies with standards for controlling emission of contaminants established by the Air Pollution Control Commission. *Approval*

S-231—To provide that the Air Pollution Control
A-585—Commission shall formulate rules establishing standards of allowable emission of contaminants from motor vehicles, standards of quality of fuels, and standards for types of air pollution control devices to prevent air pollution. *Approval*

S-230 (A-587) and S-231 (A-585) have been approved by MSNJ's Sub-committee on Air Pollution, because they incorporate the comprehensive control which was lacking in S-69 (A-137). In addition, these measures have the approval of the New Jersey State Department of Health.

The council also noted a filed correspondence from the New Jersey Tuberculosis and Health Association, recording their support of these measures "as vital and necessary to the needed expansion of air and water pollution prevention and control programs in the state."

S-266—To prohibit discrimination in issuance, extension, or renewal of any policy of automobile insurance because of race, creed, color, national origin, or ancestry, or age. *No Action*

A-177—To permit the parole of persons convicted of specified sex crimes by a special 5-member parole board appointed by the Governor, with Senate advice and consent, and with concurrence of the sentencing judge. *Disapproval* . . . because the bill does not specify the qualifications of the members of the special parole board.

A-177 was considered by the council at the request of Dr. V. Terrell Davis, Director of the Division of Mental Health and Hospitals of the Department of Institutions and Agencies. According to Dr. Davis, this legislation was recommended to the Governor by the Department of Institutions and Agencies after it had become apparent that the proce-

dure established under existing statutes for parole through the regular parole board was working contrary to the successful operation of a treatment program which has been substituted for a penal program for these selected individuals.

While the council was of the opinion that this appeared to be desirable legislation, it could not recommend approval because the "special training, experience, or qualifications" of members of the special board are not prescribed with satisfactory exactness.

A-388—To define as an unfair and deceptive practice the making of any health or accident insurance contract which excludes payments in part or in whole under another such contract without providing for a reduction in premium payments. *No Action*

*A-480—To provide for the care, treatment, and rehabilitation of the mentally ill. *Approval*

A-513—To permit suspension or denial of a pharmacist's license to anyone convicted of violating any state or federal law relating to dispensing of drugs; to prescribe acts considered grossly unprofessional and to prescribe operating criteria before a permit will be issued. *Approval*

A-514—To create "The Motor Vehicle Pollution Control Act" (1965) to control the emission of pollutants from motor vehicles; to establish a Motor Vehicle Pollution Control Board in the Department of Health and to provide for administration. *Disapproval* . . . as unnecessary, because it is a duplication of facilities provided for in S-230, for which the council recommended approval.

A-520—To exempt from examination those resident physicians of a resident medical staff who have not served as such for 5 years and within the discretion of the Board of Medical Examiners those physicians employed in a state or county institution on a salary basis on its medical staff or as a member of the teaching or scientific staff of a state agency provided they continue in such positions and do not conduct a private medical practice. *Action Deferred* . . . pending correction of the legislation.

The Legislative Analyst reported that this legislation is not in correct form; and as such, will not move until it has been revised. The council unanimously agreed not to recommend a position until such time as the bill is put in proper form. It is presently in duplication of existing law.

A-529—To require licensing and regulation of convalescent homes, private nursing homes and hospitals, and to create a hospital licensing board. *No action*

A-559—To create an 8 member commission—4 appointed by the Governor and 2 each by the president of the Senate and the Speaker of the General Assembly—to study the advisability of state aid to public and non-profit hospitals for the care of indigent patients. *No Action*

A-603—To provide for licensing of persons engaged in the practice of podiatry. *No Action*

A-609—To require pupils and teachers to use eye protective devices while attending vocational or industrial art shops or laboratories where processes are taught which may cause damage to the eyes. *No Action* . . . in view of the council's recommended approval of S-227.

*A-612—To require the use of humane methods in the slaughter of livestock. *No Action*

A-627—To change the filing date of the report of taxable personal property with an assessor from May 1 to July 1; to authorize an assessor to establish values of such property where a return has not been filed and to establish penalties for false returns or failure to file returns within the prescribed time. *No Action*

*A-636—To revise the statute creating the Division of the Aging with respect to the office of Director and the Commission on Aging. *No Action*

A-657—To grant married minors and unmarried pregnant women who are minors the legal right to consent to the performance of hospital, medical, or surgical care on themselves and their infants. *Active Support*

A-658—To permit hospitals to destroy unneeded records after a 7 year period and to destroy x-ray film after 5 years. *No Action*

A-659—To permit municipalities to lease municipal property to non-profit general hospitals, except that this shall not include real estate owned by a board of education. *No Action*

A-661—To establish a "Worker Health and Safety Act." *No Action*

A-665—To require every motor vehicle manufacturer after July 1, 1967 to be equipped with a signalling system. *Approval*

A-674—To create a nine member Automobile, Highway, and Traffic Safety Study Commission to study automobile safety devices including safety belts, headlights, steering equipment, and other safety devices, highways, and traffic regulations. *Approval* . . . subject to the appointment of a doctor of medicine as a member of the commission.

A-715—To include a school of professional nursing of collegiate grade accredited and approved by the State Board of Education under the Higher Education Assistance Authority Act. *Approval*

Medical Education Meeting . . . Received with commendation the report of Dr. Sherman Garrison as official representative to the meeting of State Chairmen of Medical Education Committees, held in Chicago recently.

Liability Panel . . . Referred to the House of Delegates for information and study a draft of proposals and procedures to govern the

establishment and operation in New Jersey of a Professional Liability Panel to evaluate medical negligence claims.

Medical-Pharmaceutical Liaison Committee . . . Approved the report of the Medical-Pharmaceutical Liaison Committee, as follows:

A. *Narcotic Prescriptions*

The Executive Officer of the New Jersey Pharmaceutical Association, Mr. Geser, reported that Assemblyman Wallwork of Essex County had been in touch with him, seeking assistance—possibly through legislation—to overcome the increasing number of forged prescription blanks calling for narcotics or barbiturates. It was Mr. Geser's opinion—which he conveyed to Mr. Wallwork—that such assistance should be obtained through MSNJ. Mr. Geser was assured that our Society has already been active in this area for over three months, as evidenced by two items in the May 1965 issue of THE JOURNAL.

(1) Editorial on page 160, "Omit Your Narcotic Number."
(2) Excerpt from minutes of February 24 meeting of Board of Trustees on page 186, "Forged Drug Prescriptions."

Mr. Nevin agreed to send a copy of THE JOURNAL to Assemblyman Wallwork, calling his attention to these two items.

B. *Editorial in April 1965 Issue*

Representatives of the Pharmaceutical Association wanted to know if the editorial, "The Rising Tide of Self-Medication" (which appeared in the April 1965 issue of THE JOURNAL), represented the official thinking of MSNJ or merely reflected the opinion of the Editor. Representatives of the Pharmaceutical Association interpreted the editorial as advocating or supporting self-medication.

Repreeentatives of MSNJ pointed out that the introductory sentence of the editorial refuted this erroneous interpretation: "As doctors, we have always frowned on self-medication by untutored laymen. The reasons are obvious . . ." The editorial reports on a meeting in New York where many outstanding, authoritative representatives of Medicine suggested that ". . . maybe self-medication isn't so bad after all."

All present agreed that there was nothing in the editorial which proved divergent to the Society's long-standing policy of disapproval of self-medication on the part of the public.

C. *Self-Medication Legislation*

Pharmaceutical representatives asked if MSNJ would ever consider changing its position of "approval" to one of "active support" on bills in which the Pharmaceutical Association is interested.

Mr. Nevin explained that it is the policy of the Society to support actively only those measures which it has caused to be introduced. However, he suggested that Mr. Geser send the specific bills which the Pharmaceutical Association would like MSNJ to support. They will be referred to the Legislative Analyst and to the Council on Legislation for study and recommendation.

D. *"Health Displays" in Drug Stores*

The Pharmaceutical Association's President-Elect, Mr. Wernick explained that the APHA selected random drug stores throughout the country to set up "health displays," from which members of the public could take flyers and brochures on general health subjects. It proved so successful that the APHA inaugurated its own program.

The New Jersey Pharmaceutical Association suggested that MSNJ cooperate with them in establishing such "health center displays" in drug stores throughout the State and supply appropriate materials for distribution.

Dr. Kustrup promised to refer the matter to the Council on Public Relations for study and comment.

E. *Local Medical-Pharmaceutical Meetings*

The Pharmaceutical Association suggested that joint meetings at county level would evoke greater interest and understanding between medicine and pharmacy. Representatives asked that, at state level, MSNJ assist in bringing such meetings about.

It was pointed out that county societies are autonomous and the State Society cannot tell them what programs they should have. However, it was suggested that the Pharmaceutical Association make contact directly with those counties in which they want to hold joint meetings and offer assistance in setting them up. It was further suggested that the Pharmaceutical Association start with two counties, on a trial basis. If these prove successful, they could be continued among the other counties.

It was also suggested to the Pharmaceutical Association that they might establish liaison committees locally between their members and members of component societies, to discuss informally such items as were brought to light today at state level.

The representatives of the Pharmaceutical Association agreed that this suggestion was worth exploring.

F. *Articles in Official Publications*

Representatives of the Pharmaceutical Association were of the opinion that they could supply articles which, if published in THE JOURNAL of MSNJ, would be of great help to members of our Society; while articles in their official publication from members of MSNJ could prove mutually beneficial to their members. They asked if such an exchange were possible.

They were urged to submit such articles promptly, for consideration for publication in THE JOURNAL.

G. *Brochure of Specific Suggestions*

Representatives of the Pharmaceutical Association said there were several other areas in which they and the Medical Society could assist each other; and these suggestions might be incorporated in a brochure for distribution among pharmacists and physicians.

The Pharmaceutical Association was urged to submit to MSNJ such a compilation for study and comment.

2. Representatives of MSNJ presented the following items for discussion, which were disposed of as indicated:

A. *Narcotic Addiction*

As the result of a resolution (#1—from Middlesex County) adopted by the 1964 House of Delegates, the Council on Public Relations has been asked to "engage in a statewide education program to prevent drug addiction in conjunction with our law enforcement agencies."

It was agreed by the council that there were areas of the problem with which physicians should be more familiar before undertaking such an education program. Dr. Kustrup and Dr. Tomlins were invited to today's meeting to discuss this matter with representatives of the Pharmaceutical Association.

As the result of the discussion, the Pharmaceutical Association agreed to draw up for MSNJ a list of the most commonly used 200 drugs and to break them down into three categories, according to their habit-forming or addictive qualities.

Pension Plan . . . Directed the Pension Plan Committee to pursue with the Internal Revenue Service in Newark the possibility of increasing salary levels without increasing pension contributions for the staff member involved under the Society's Pension Plan for employees.

Payment of Interns and Residents . . . Approved the following resolution for introduction at the June AMA meeting concerning payment of interns and residents by Blue Shield Plans:

Whereas, the House of Delegates of the American Medical Association in June of 1963 recorded itself as "opposed to any system or program by which any part of an intern's or resident's salary is paid out of fees collected by the attending physician or out of fees collected under any type of medical-surgical insurance coverage," which action of the House has never been rescinded; and

Whereas, the National Association of Blue Shield Plans, at its recent meeting in San Francisco, refused to adopt the principle that rendered to private patients, wherever possible; and

Whereas, there is an increasing tendency for hospitals to have residents and interns collect fees, under prepaid medical-surgical insurance, for services rendered to clinic patients; and

Whereas, there is also a tendency on the part of hospitals to set up clinics for the treatment of patients having prepaid medical surgical insurance coverage; and

Whereas, these developments would defeat the purpose for which Blue Shield and other voluntary medical-surgical plans were sponsored and established by the medical profession, which was to enable the insured patient to obtain private care from private physicians of their own choice; and

Whereas, the care of medical-surgical insurance subscribers by interns and residents and by paid hospital staff members constitutes a most serious threat to the private practice of medicine; and

Whereas, the salaries of interns and residents are paid by hospitals, which are in turn reimbursed for those salaries by Blue Cross Plans, whose rates are factored for such reimbursement; and

Whereas, in consequence the salaries of interns and residents should not again be paid by Blue Shield Plans; now therefore be it

Resolved, that this House of Delegates record itself as approving and supporting the principle that Blue Shield medical-surgical insurance benefits should be paid only to private physicians for eligible professional services personally rendered to their private patients; and be it further.

Resolved, that this House of Delegates report its action to the National Association of Blue Shield Plans and to all constituent associations and component societies of the American Medical Association for the purpose of encouraging widespread adherence to this principle.

Resolutions and Publicity . . . Directed that component societies be informed of the proper procedure in presenting resolutions to the MSNJ House of Delegates; urged that resolutions adopted by component societies be not given out to the press in advance of their consideration and study by reference committees and action by the House.

May 19, 1965

The reorganization meeting of the Board of Trustees for 1965-66 was held in Atlantic City on Wednesday morning at Haddon Hall. For the further information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Officers . . . Elected Dr Nicholas A. Bertha of Wharton as Chairman of the Board of Trustees for 1965-66; and Dr. Emanuel M. Satulsky of Elizabeth, as Secretary.

Finance and Budget . . . Elected Dr. Nicholas E. Marchione of Vineland to membership on

the Finance and Budget Committee for a term of 3 years; elected Dr. Thomas C. DeCecio of Cliffside Park for two years, to fill the unexpired term of Dr. Carl N. Ware of Ocean City.

Salaried Personnel . . . Re-appointed for 1965-1966 at the salaries set forth in the adopted budget for 1965-66 all salaried personnel not under individual contract, including the Legislative Analyst.

AMA Meeting . . . Authorized the following to attend the June 1965 American Medical Association meeting in New York City with expenses paid: President, President-Elect, Executive Director, and three alternate delegates: Dr. Jerome G. Kaufman, Dr. Louis S. Wegryn, and Dr. F. Clyde Bowers.

Air Pollution . . . Carried out the directive of the House to make the Subcommittee on Air Pollution a special committee under the Council on Public Health.

Mental Health Centers . . . Referred to the AMA delegates Resolution #5, community mental health centers, with instructions to introduce and support a resolution calling upon the AMA likewise to encourage the enactment of HR-2985 and S-513.

Professional Liability Panel . . . Referred back to the Conference Committee with the Judiciary and the Bar the proposal for a Professional Liability Panel, as requested by the House of Delegates.

Directed that a copy of the proposed plan be brought to the attention of the members through the *Membership News Letter*, soliciting constructive comments and suggestions.

Committee Structure . . . Continued—at the request of the House—the special committee to Study the Special Committee Structure of the Society.

Meeting Schedule . . . Agreed to continue meeting the third Sunday of each month at 10:45 a.m. at the Executive Offices in Trenton.

Conference on Physicians and Schools . . . Designated Dr. Robert E. Jennings, chairman of the Society's Committee on Child Health, as the Society's official representative to the 10th National Conference on Physicians and Schools, to be held in Chicago September 23-25.

Mental Health Conference . . . Named Dr. Eugene V. Resnick, of Paramus, as the Society's official representative to the 2nd State Mental Health Planning Conference held in Princeton June 28-29.

National (AMA) Programs . . . Approved the following resolution, for introduction at the 1965 AMA meeting:

Whereas, the AMA national educational campaign (October 1964) which sought to establish that the adequacy of existing Kerr-Mills programs rendered unnecessary the adoption of a federal medicare tax program was launched by the American Medical Association without preliminary conference or consultation with official representatives of constituent associations, and, as a result of lack of unity of understanding and of action, had only a very limited success; and

Whereas, the AMA national educational campaign in behalf of the Herlong-Curtis Eldercare Bill (March 1965) was preceded by a conference of official representatives of constituent associations and—as the AMA reported, on the basis of opinion polls—was markedly successful in achieving popular support for the eldercare proposals; now therefore be it

Resolved, that—in the interest of unity of action and of the full and energetic support of national programs of this kind by all constituent associations, component societies, and individual members—in the future, the American Medical Association continue to afford constituent associations the opportunity of discussing and formally concurring in proposed national programs either by vote of their delegates at AMA meetings, or by vote of authorized representatives taken at special conferences held for that purpose.

1966 Annual Meeting . . . Recommended to the Annual Meeting Committee that the reception for the President-Elect in 1966 be held on Sunday evening, and that the Reception-Buffet for Technical Exhibitors be held on Tuesday evening.

Haddon Hall . . . Directed a formal letter of complaint from the Board to Haddon Hall concerning the "below quality food, poor service, and discourtesy on the part of some elevator operators during the 1965 Annual Meeting."

Bicentennalia

NEW BRUNSWICK: BIRTHPLACE OF OUR SOCIETY.

Chronologically the oldest state medical society in the United States, The Medical Society of New Jersey was founded July 23, 1766 at a meeting in New Brunswick. The seventeen physicians who adopted the "Instruments of Association" on that day met in response to a notice, in the New York *Mercury* newspaper, dated June 27, 1766. This read: "A considerable number of the Practitioners in Physic and Surgery . . . having agreed to form a Society for their mutual improvement, the advancement of the profession and promotion of the public good . . . hereby request and invite every gentleman of the profession in the province to attend their first meeting, which will be held at Mr. Duff's, in the City of New Brunswick, on Wednesday, the 23rd of July, at which time and place the Constitution and Regulations of the Society are to be settled and subscribed."

Formed a decade before the Declaration of Independence, The Medical Society of New Jersey is older than the nation itself. Now numbering more than 7000 members, it has flourished for two centuries—years filled with growth and change, science and service.

The State of New Jersey recently marked the site of its founding in New Brunswick. A commemorative plaque at the northeast corner of Albany and Peace Streets (near the Raritan River bridge) states: "The Medical Society of New Jersey—oldest state medical organization in the nation—was founded here, at Duff's Inn, in 1766."

While heralding the two hundreth anniversary of the Medical Society in 1966, New Brunswick in that year will see the observance of the bicentennial of Rutgers, The State University, and the admission of the first class into its School of Medicine.

The title page of the original minute book of The Medical Society of New Jersey, preserved at The New Jersey Historical Society, bears the following quotation from the Harveian Oration for 1748 by Dr. Richard Mead (1673-1754) to the Royal College of Physicians of London.

Amant, enim societatem Scientiae; et Concordia, tanquam communi anima, vigent.

They love therefore the fellowship of Science; and they thrive through Concord as well as common spirit.

FRED B. ROGERS, M.D.

Mrs. Yaguda Becomes AMA Auxiliary Leader

Mrs. Asher Yaguda of New Jersey was named president-elect of the Woman's Auxiliary to the AMA at the June 1965 convention. For the second time within a few years, a New Jersey woman heads up this 88,000 member organization. (The only New Jersey AMA-Auxiliary president was the late Mrs. David Allman of Atlantic City.)

A pioneer of the New Jersey Homemaker Service program, Mrs. Yaguda is currently a trustee of the National Council for Homemaker Service and chairman of its Committee on Standards. She is also chairman of the State Health Department's Committee on Friendly Visitors and is a member of the State Board of Public Welfare.

She has served as president of the New Jersey Health and Sanitary Association (now the Public Health Association), chairman of the New Jersey Public Medical Care Commission and a delegate to two White House Conferences—Children and Youth and Aging.

Mrs. Yaguda was named 1959-60 Woman of the Year by the Essex County Council of Business and Professional Women's Clubs.

Committees and Councils

Alternate Delegates to AMA

Matthew E. Boylan, M.D. (1966) . . . Jersey City
F. Clyde Bowers, M.D. (1966) . . . . Mendham
Jerome G. Kaufman, M.D. (1966) . . Maplewood
John F. Kustrup, M.D. (1966) . . . . . Trenton
Joseph R. Jehl, M.D. (1967) . . . . . Clifton
Robert E. Verdon, M.D. (1967) . . . Cliffside Park
Louis S. Wegryn, M.D. (1967) . . . . . Elizabeth

Delegates to Other States

Delegates

New York—Joseph P. Donnelly, M.D. (1966) Jersey City
Connecticut—Lloyd A. Hamilton, M.D.
(1966) . . . . . Lambertville

Alternates

New York—Paul H. Steel, M.D. (1966) . . Atlantic City
Connecticut—Josiah C. McCracken, Jr., M.D.
(1966) . . . . . Ventnor

STANDING COMMITTEES

Annual Meeting

Jerome G. Kaufman, M.D., *Chairman*
(1968) . . . . . Maplewood
Edward E. P. Seidmon, M.D., *Vice-Chairman*
(1967) . . . . . Plainfield
Milton Ackerman, M.D. (1966) . . . . . Atlantic City
George J. Kohut, M.D. (1968) . . . . . Perth Amboy
Peter H. Marvel, M.D. (1967) . . . . . Northfield
Herschel S. Murphy, M.D. (1966) . . . . . Roselle
Marcus H. Greifinger, M.D., *Secretary*
Ex-Officio . . . . . Newark

*Scientific Exhibits

Milton Ackerman, M.D., *Chairman* (1966) Atlantic City
Arthur Bernstein, M.D. (1966) . . . . . Maplewood
Louis K. Collins, M.D. (1966) . . . . . Glassboro
Thomas K. Rathmell, M.D. (1966) . . . . . Trenton
Robert E. Verdon, M.D. (1966) . . . . . Cliffside Park

*Scientific Program

Herschel S. Murphy, M.D., *Chairman* (1966) . Roselle
Chairmen and Secretaries of Scientific Sections

Allergy

Maclyn Cagan, M.D., *Chairman* . . . . . Rahway
Roslyn Barbash, M.D., *Secretary* . . . . . Teaneck

Anesthesiology

Stephen H. Mazur, M.D., *Chairman* . . . . Short Hills
Francis G. Casey, Jr., M.D., *Secretary* . . N. Plainfield

Cardiovascular Diseases

Marvin C. Becker, M.D., *Chairman* . . . . . Millburn
Gilbert E. Levinson M.D., *Secretary* . . . . . Jersey City

Chest Diseases

Mervin G. Olinger, M.D., *Chairman* . . . . . Verona
Alfred Yager, M.D., *Secretary* . . . . . North Bergen

Clinical Pathology

S. Raymond Gambino, M.D., *Chairman* . . Englewood
Jacques B. Wallach, M.D., *Secretary* . . . . . Westfield

Dermatology

Sam C. Atkinson, M.D., *Chairman* . . . . . Morristown
Hugh McCulloch, Jr., M.D., *Secretary* . . . . Plainfield

Gastroenterology and Proctology

Abraham I. Friedman, M.D., *Chairman* . . Hackensack
Robert Horowitz, M.D., *Secretary* . . . . . Jersey City

General Practice

Gustav L. Ibranyi, M.D., *Chairman* . . . . . Newark
Victor H. Boogdanian, M.D., *Secretary* New Brunswick

Medicine

Joseph A. Linsk, M.D., *Chairman* . . . . Atlantic City
Milton Cutler, M.D., *Secretary* . . . . . Atlantic City

Metabolism

Murray D. Shepp, M.D., *Chairman* . . . . . Trenton
Henry A. Terwedow, M.D., *Secretary* . . North Bergen

Obstetrics and Gynecology

Robert E. Sexton, M.D., *Chairman* . . . . Point Pleasant
James L. Breen, M.D., *Secretary* . . . . . Newark

Ophthalmology

Anthony M. Sellitto, M.D., *Chairman* . . South Orange
Oram R. Kline, Jr., *Secretary* . . . . . Camden

Orthopedic Surgery

Robert G. Greene, M.D., *Chairman* . . . . . Montclair
John J. Reilly, Jr., M.D., *Secretary* . . . . . Elizabeth

Otolaryngology

Thomas F. Flynn, Jr., M.D., *Chairman* . . . Woodbury
August P. Ciell, M.D., *Secretary* . . . . . Haddonfield

Pediatrics

Robert Forer, M.D., *Chairman* . . . . . Trenton
Suzanne A. Widrow, M.D., *Secretary* . . . . . Hanover

Psychiatry and Neurology

Arnold M. Kallen, M.D., *Chairman* . . . . . Newark
Bernard R. Goldberg, M.D., *Secretary* . . . East Orange

Radiology

John W. Marquis, M.D., *Chairman* . . . . . Chatham
John R. Helff, M.D., *Secretary* . . . . . New Brunswick

Rheumatism

Georgia E. Allen, M.D., *Chairman* . . Haddon Heights
Peter W. Vanace, M.D., *Secretary* . . . . . Haddonfield

Surgery

William E. Philip, M.D., *Chairman* . . . . Morristown
Adolph R. Wichman, M.D., *Secretary* . . . . . Denville

Urology

Robert L. Lieb, M.D., *Chairman* . . . . . South Orange
Anthony R. Fernicola, M.D., *Secretary* . . . . . Newark

Credentials

Marcus H. Greifinger, M.D., *Chairman*
(Secretary) . . . . . Newark
Eugene J. Tyrrell, M.D., *Vice-Chairman*
(1967) . . . . . Perth Amboy
William E. Bray, M.D. (1967) . . . . . Pemberton
S. Thomas Camp, M.D. (1966) . . . . . Westville
Charles P. Campbell, M.D. (1968) . . . . . Hackensack
Elton W. Lance, M.D. (1968) . . . . . Rahway
Raymond A. McCormack, M.D. (1966) . . . . . Trenton

Finance and Budget

Thomas C. DeCecio, M.D., *Chairman*
(1967) . . . . . Cliffside Park

* Subcommittee of Annual Meeting Committee.

Theodore K. Graham, M.D., *Vice-Chairman* (1966) ..... Paterson
Charles A. Landshof, M.D. (1968) ..... Jersey City
Samuel J. Lloyd, M.D. (1966) ..... Trenton
Nicholas E. Marchione, M.D. (1968) ..... Vineland
John S. Van Mater, M.D. (1967) ... New Brunswick
Daniel F. Featherston, M.D., *Treasurer* Ex-Officio ..... Asbury Park

Honorary Membership

F. Clyde Bowers, M.D., *Chairman* (1967) .. Mendham
Spencer T. Snedecor, M.D., *Vice-Chairman* (1966) ..... Hackensack
David B. Allman, M.D. (1968) ..... Atlantic City

Medical Defense and Insurance

Daniel F. Featherston, M.D., *Chairman* (1967) ..... Asbury Park
Fred A. Mettler, M.D., *Vice-Chairman* (1966) ..... Greystone Park
Ernest C. Hillman, Jr., M.D. (1966) ..... Newark
Elton W. Lance, M.D. (1968) ..... Rahway
Jesse Schulman, M.D. (1968) ..... Lakewood
Benjamin F. Slobodien, M.D. (1967) .. Perth Amboy
Marcus H. Greifinger, M.D., *Secretary* Ex-Officio ..... Newark

Medical Education

Sherman Garrison, M.D., *Chairman* (1968) . Bridgeton
Andrew C. Ruoff, III, M.D., *Vice-Chairman* (1966) ..... Pompton Plains
Louis F. Albright, M.D. (1966) ..... Spring Lake
Frank S. Fort, M.D. (1968) ..... Newark
John W. Nicholson, III, M.D. (1967) .... Moorestown
Morris H. Saffron, M.D. (1967) ..... Passaic

Medical Student Loan Fund

Luke A. Mulligan, M.D., *Chairman* (1968) ... Leonia
Frank J. Hughes, M.D., *Vice-Chairman* (1968) ..... Gloucester
Nicholas A. Bertha, M.D. (1966) ..... Wharton
Louis K. Collins, M.D. (1967) ..... Glassboro
John F. Kustrup, M.D. (1967) ..... Trenton

Publication

George B. Sharbaugh, M.D., *Chairman* (1966) Trenton
C. Spencer Davison, M.D. (1967) ..... Salem
James J. Fitzpatrick, M.D. (1968) ..... Trenton
Joseph R. Jehl, M.D., *President-Elect* Ex-Officio ..... Clifton
Marcus H. Greifinger, M.D., *Secretary* Ex-Officio ..... Newark
Henry A. Davidson, M.D., *Editor* Ex-Officio ..... Cedar Grove

Revision of Constitution and Bylaws

Louis F. Albright, M.D., *Chairman* (1968) Spring Lake
Joseph M. Gannon, M.D., *Vice-Chairman* (1968) ..... Plainfield
Sherman Garrison, M.D. (1967) ..... Bridgeton
John A. Smith, M.D. (1966) ..... South River
John J. Thompson, M.D. (1966) ..... Caldwell
Robert E. Verdon, M.D. (1967) ..... Cliffside Park
Marcus H. Greifinger, M.D., *Secretary* Ex-Officio ..... Newark

Woman's Auxiliary Advisory

George O. Rowohlt, M.D., *Chairman* (1966) Dumont
Keith R. Young, M.D., *Vice-Chairman* (1967) ..... Burlington
Ralph K. Bush, M.D. (1968) ..... Merchantville
Edward M. Coe, M.D. (1967) ..... Cranford
Thomas H. McGlade, M.D. (1968) ..... Camden
Volmar A. Mereschak, M.D. (1966) ..... Phillipsburg

ADMINISTRATIVE COUNCILS

Legislation

Jesse McCall, M.D., *Chairman* (1966) ... Newton
A. Guy Campo, M.D., *Vice-Chairman* (1967) Westville
Meyer L. Abrams, M.D. (1968) ..... Willingboro
Charles L. Cunniff, M.D. (1968) ..... Jersey City
Winton H. Johnson, M.D. (1966) ..... Hackensack
John S. Madara, M.D. (1966) ..... Salem
Henry J. Mineur, M.D. (1966) ..... Cranford
Robert E. Murto, M.D. (1967) ..... Trenton
Francis A. Pflum, M.D. (1968) ..... Asbury Park
Nathan J. Plavin, M.D. (1967) ..... North Bergen
Leonard Rosenfeld, M.D. (1967) ..... Ringoes
Ludwig L. Simon, M.D. (1968) ..... Newark
Nicholas A. Bertha, M.D., *Chairman, Board of Trustees* Ex-Officio ..... Wharton

Medical Services

Nicholas E. Marchione, M.D., *Chairman* (1968) ..... Vineland
Andrew C. Ruoff, III, M.D., *Vice-Chairman* (1967) ..... Pompton Plains
Donald T. Akey, M.D. (1968) ..... Metuchen
Francis J. Benz, M.D. (1968) ..... Chatham
Harry R. Brindle, M.D. (1966) ..... Asbury Park
Leonard Brown, M.D. (1967) ..... Hackensack
Frederick W. Durham, M.D. (1968) .... Haddonfield
Karl T. Franzoni, M.D. (1967) ..... Trenton
Frank M. Galioto, M.D. (1966) ..... Bloomfield
Joseph M. Gannon, M.D. (1967) ..... Plainfield
Charles B. Norton, Jr., M.D. (1966) ..... Woodstown
I. Edward Ornaf, M.D. (1966) ..... Camden
Joseph R. Jehl, M.D., *President-Elect* Ex-Officio ..... Clifton

Public Health

John B. Fuhrmann, M.D., *Chairman* (1968) ..... Flemington
John P. Coughlin, M.D., *Vice-Chairman* (1966) ..... Jersey City
Edwin H. Albano, M.D. (1967) ..... East Orange
Roslyn Barbash, M.D. (1967) ..... Teaneck
Charles Cunningham, M.D. (1966) ..... Vineland
Anthony P. DeSpirito, M.D. (1968) ... Neptune City
Henry L. Drezner, M.D. (1968) ..... Trenton
Elmer J. Elias, M.D. (1967) ..... Trenton
Peter J. Guthorn, M.D. (1966) ..... Neptune
Marion F. Kaletkowski, M.D. (1967) ..... Clifton
Henry J. Konzelmann, M.D. (1968) ..... Hillside
Carl J. Records, M.D. (1966) ..... Cape May
Louis K. Collins, M.D., *1st Vice-President* Ex-Officio ..... Glassboro
Roscoe P. Kandle, M.D., Commissioner, New Jersey State Department of Health, *Consultant* ..... Trenton

Public Relations

Harry F. Suter, M.D., *Chairman* (1967) . Penns Grove
William P. Mulford, M.D., *Vice-Chairman* (1968) ..... Beverly
George E. Barbour, M.D. (1967) ..... Somerville
Norman K. Boudwin, M.D. (1967) ..... Beverly
F. Clyde Bowers, M.D. (1967) ..... Mendham
John J. Crosby, Jr., M.D. (1966) ..... Jersey City
S. William Kalb, M.D. (1968) ..... Newark
Josiah C. McCracken, Jr., M.D. (1966) .... Ventnor
Howard C. Pieper, M.D. (1968) ..... Keyport
William E. Ryan, M.D. (1968) ..... Trenton
Francis I. Tomlins, M.D. (1966) ..... Ridgewood
Earl L. Warren, M.D. (1966) ..... Paterson
John F. Kustrup, M.D., *2nd Vice-President* Ex-Officio ..... Trenton

SPECIAL COMMITTEE TO THE ADMINISTRATIVE COUNCIL ON MEDICAL SERVICES

Occupational Health, Workmen's Compensation, and Rehabilitation

Joseph A. Lepree, M.D., *Chairman* (1966) . Elizabeth
Delma W. Caldwell, M.D. (1966) . . . . . Linden
E. Vernon Davis, M.D. (1966) . . . . . Mount Holly
William J. D'Elia, M.D. (1966) . . . . . Spring Lake
Elmer J. Elias, M.D. (1966) . . . . . Trenton
Lloyd A. Hamilton, M.D. (1966) . . . . . Lambertville
Carl A. Maxwell, M.D. (1966) . . . . . Phillipsburg
Robert J. Neville, M.D. (1966) . . . . . Hackensack
Andrew C. Ruoff, III, M.D. (1966) . . Pompton Plains
William D. Van Riper, M.D. (1966) . New Brunswick
Mathilda R. Vaschak, M.D. (1966) . . New Brunswick
Ralph A. Young, M.D. (1966) . . . . . Linden
Joshua N. Zimskind, M.D. (1966) . . . . . Trenton

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON PUBLIC HEALTH

Air Pollution

Roslyn Barbash, M.D., *Chairman* (1966) . . . Teaneck

Cancer Control

John L. Olpp, M.D., *Chairman* (1966) . . Englewood
William E. Bray, M.D. (1966) . . . . . Pemberton
George L. Erdman, M.D. (1966) . . . . . Summit
Roy T. Forsberg, M.D. (1966) . . . . . Westfield
Bernard Koven, M.D. (1966) . . . . . Englewood
Sylvan E. Moolten, M.D. (1966) . . . . Highland Park

Child Health

Robert E. Jennings, M.D., *Chairman* (1966) . . . . . South Orange
Neil Castaldo, M.D. (1966) . . . . . Cranford
William J. Farley, M.D. (1966) . . . . . Nutley
David R. Lyons, M.D. (1966) . . . . . East Orange
Vincent J. McAuliffe, M.D. (1966) . . . . . Teaneck
Thomas P. McFarland, Jr., M.D. (1966) Mays Landing
Bernard N. Millner, M.D. (1966) . . . . . Trenton
Eli Rubenstein, M.D. (1966) . . . . . Bayonne
Sydney Tucker, M.D. (1966) . . . . . Perth Amboy
Charles O. Tyler, M.D. (1966) . . . . . Haddonfield

Chronically Ill and the Aging

Matthew E. Boylan, M.D., *Chairman* (1966) . . . . . Jersey City
David Eckstein, M.D. (1966) . . . . . Trenton
William H. Hahn, M.D. (1966) . . . . . Newark
William D. Kimler, M.D. (1966) . . . . Haddon Heights
Thomas E. Mattingly, M.D. (1966) . . . . Mount Holly
Sol Parent, M.D. (1966) . . . . . Newark
Johannes F. Pessel, M.D. (1966) . . . . . Trenton
Abram L. Van Horn, M.D. (1966) . . . . . Far Hills

Conservation of Hearing and Speech

James Brennan, M.D. (1966) . . . . . East Orange
Edgar P. Cardwell, M.D. (1966) . . . . . East Orange
Warren E. Crane, M.D. (1966) . . . . . Trenton
Arthur Dintenfass, M.D. (1966) . . . . . Atlantic City
Julio T. Noguera, M.D. 1966) . . . . . Neptune
Aris M. Sophocles, M.D. 1966) . . . . . Trenton
James H. Spillane, M.D. 1966) . . . . . Phillipsburg

Conservation of Vision

Ralph E. Siegel, M.D., *Chairman* (1966) Perth Amboy
Henry Abrams, M.D. (1966) . . . . . Princeton
Alfonse A. Cinotti, M.D. (1966) . . . . . Jersey City
Samuel M. Diskan, M.D. (1966) . . . . . Atlantic City
William H. Hahn, M.D. (1966) . . . . . Newark
Joseph H. Kler, M.D. (1966) . . . . . New Brunswick
Oram R. Kline, M.D. (1966) . . . . . Camden
Robert E. Murto, M.D. (1966) . . . . . Trenton
D. Blair Sulouff, M.D. (1966) . . . . . Morristown
Frank B. Vanderbeek, M.D. (1966) . . . . . Paterson
John T. Worcester, M.D. (1966) . . . . . Englewood

Maternal and Infant Welfare

John D. Preece, M.D., *Chairman* (1966) . . . Trenton
Mary Bacon, M.D. (1966) . . . . . Bridgeton
Robert A. Cosgrove, M.D. (1966) . . . . . Jersey City
Frederick J. Faux, M.D. (1966) . . . . . Woodbury
Edward Foord, M.D. (1966) . . . . . Burlington
Theodore K. Graham, M.D. (1966) . . . . . Paterson
Theodore Loizeaux, M.D. (1966) . . . . . Plainfield
Frank L. Paret, M.D. (1966) . . . . . New Brunswick
Daniel B. Roth, M.D. (1966) . . . . . Teaneck
Francis U. Seiler, M.D. (1966) . . . . . Trenton
Merrill A. Swiney, III, M.D. (1966) . . . . . Jersey City
Ralph H. Van Meter, M.D. (1966) . . . . . Moorestown
Curtis F. Culp, M.D., Director, Division of Constructive Health, New Jersey Department of Health, *Consultant* . . . . . Trenton

Mental Health

Robert S. Garber, M.D., *Chairman* (1966) Belle Mead
Joseph C. Borrus, M.D. (1966) . . . . . New Brunswick
David I. Canavan, M.D. (1966) . . . . . Oakland
Francesco A. Figurelli, M.D. (1966) . . . . . Jersey City
James B. Goyne, M.D. (1966) . . . . . Trenton
Thomas R. Houseknecht, M.D. (1966) . Moorestown
J. Lloyd Morrow, M.D. (1966) . . . . . Passaic
Edward A. Schauer, M.D. (1966) . . . . . Farmingdale
Martin H. Weinberg, M.D. (1966) . . . . . Hammonton
Evelyn P. Ivey, M.D., *Consultant* . . . . . Morristown

SPECIAL COMMITTEES

Disaster Medical Care

Jack R. Karel, M.D., *Chairman* (1966) . . . . . Hillside
R. Winfield Betts, M.D. (1966) . . . . . Medford
Albert Ehrlich, M.D. (1966) . . . . . Fort Lee
Sidney Ketyer, M.D. (1966) . . . . . South Orange
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Frank L. Paret, M.D. (1966) . . . . . New Brunswick
Lynn A. Parry, M.D. (1966) . . . . . Asbury Park
Frank R. Schell, M.D. (1966) . . . . . Butler
Marie A. Sena, M.D., *Consultant* . . . . . Linden

Medicine and Religion

Jerome G. Kaufman, M.D., *Chairman* (1966) . . . . . Maplewood
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John S. Madara, M.D. (1966) . . . . . Salem
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Luke A. Mulligan, M.D. (1966) . . . . . Leonia

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., *Chairman* (1966) . . . . . Vineland
Albert F. Moriconi, M.D. (1966) . . . . . Trenton
Raphael E. Remondelli, M.D. (1966) . . . . . Belleville
Herbert W. Weisman, M.D. (1966) . . . . . Bayonne

Traffic Safety

William L. Sprout, M.D., *Chairman* (1966) . Salem
Donald T. Akey, M.D. (1966) . . . . . Metuchen
R. Winfield Betts, M.D. (1966) . . . . . Medford
Robert S. Garber, M.D. (1966) . . . . . Belle Mead
John F. Kustrup, M.D. (1966) . . . . . Trenton
Ralph E. Siegel, M.D. (1966) . . . . . Perth Amboy

LETTERS TO THE JOURNAL

M. D. Control of Mental Health installations.

Dear Sir:

At our Annual Meeting this May, a Reference Committee brought in a report suggesting that our Society *oppose* HR-2985, the National Mental Health Bill. In spite of this negative report, our House of Delegates, in true and effective democratic tradition, listened to all sides of the matter and voted to instruct our AMA delegates to *support* the bill. This wise decision lines us up with 15,000 of our colleagues in the American Psychiatric Association who have not only supported, but actively encouraged this kind of constructive legislation. In making this decision, our House of Delegates indicated that they had grasped the fact that the New Jersey Community Mental Health Act has been in existence for many years now. They recalled the struggle with organized "handmaiden" services necessary to keep the operation of mental health facilities under the active, responsible, and ethical control of the medical profession. If we had backed off from this situation or just remained inactive, we would be abdicating control of mental health facilities to psychologists and social workers who would hire physicians.

Only by active *medical* leadership can our standards of ethics be applied to Community Mental Health Centers. These include:

1. Twenty-four-hour per day response to emergency calls.
2. Therapist-to-patient responsibility on a twenty-four-hour per day, seven-day per week basis.
3. Responsibility for treatment upon acceptance of patient for diagnosis.
4. Medico-legal liability insurance coverage of therapist for patient.

The day of the traditional "clinic" has passed. Social workers think of the Child Guidance Center as the model for future planning. They are simply unaware of the advances that have been made by private practicing psychiatrists and neurologists in this area. They state in public (and write into some county Mental Health Board plans) formulae predicated on the assumption that clinic practice is good and private practice is avaricious. Actually, in my judgment, the psychiatric clinic is an anachronism. To use the child guidance center as a model in this age would inflict an atavistic throwback upon the unsuspecting public. The common practice of these clinics of accepting children for diagnostic categorization with lists waiting for one or two years for treatment makes such clinics only enticing menaces in the paths of anxious parents seeking fulfillment of unfillable implied promises.

Any mental health facility that promises more than it can fulfill is specious, hazardous, and contrary to the general emotional well being. Thus, any installation to be dignified by the title *Mental Health Center* must by law be open twenty-four hours a day, seven days a week with therapist-to-patient responsibility on a 24-hour a day basis, with treatment responsibility predicated on scientific medical diagnosis and underwritten by medico-legal responsibility. These principles can be met only by licensed physicians capable of taking responsibility for ancillary co-workers. They can never be met by narrowly trained ancillary professional help, no matter how skilled in any one aspect of the healing art. This goes for psychologists, social workers, marriage counsellors, clergymen, and business managers. Do you know the one area in which physicians have retained control of hospitals? This is the state hospital and county hospital for the mentally ill, where M.D.'s are still in the saddle. In these days of generous federal subsidy, general hospitals are becoming more and more socially subsidized. Let us look to the medical superintendents of state and county mental hospitals to learn how to restore hospitals to medical supervision.

Already doctors have lost general hospital control to the business man. Let us not lose control of community mental health centers to psychologists and social workers. To retain medical control, we must support H.R. 2985 and S. 513.

Ira S. Ross, M.D.

ANNOUNCEMENTS

Conference on Adolescent Gynecology

Pediatricians and gynecologists will be interested in an unusual three-day conference to be held on Thursday through Saturday, March 24-26, 1966, at the Waldorf Astoria in New York City.

For a detailed program, write to Dr. Warren R. Lang of the Jefferson Medical College of Philadelphia at 1025 Walnut Street.

Course in Oral Region Cancer

Our Medical Society—together with the State Dental Society and the State Health Department—is sponsoring a unique course in cancer of the oral regions. Presented on five consecutive Wednesdays, starting on September 22, the classes will be held all day (9 a.m. to 5 p.m.) at the Fairleigh Dickinson School of Dentistry in Teaneck. No registration or tuition fees will be charged, but advance enrollment is essential. Write to Department of Pathology, Fairleigh Dickinson School of Dentistry, 1002 River Road, Teaneck, New Jersey.

AMA Health Guide Available

The AMA has available a new manual of health information and guidance for the American family. Entitled *Today's Health Guide,* it is sold at $5.95. Orders received within the next few weeks are available at an introductory price of $4.95. As soon as this initial supply is exhausted, the regular price of $5.95 will apply. This is a profusely illustrated, 650-page book, ranging from information about drugs, mental health, and physical handicaps to explanations of first aid, recreation, recognition of quacks, and tips for travelers. The book is an anthology of contributions from 200 experts.

Suicide Symposium

The George Washington University School of Medicine will conduct a symposium on suicide on October 14, 1965, in the Lisner Auditorium in Washington, D.C. It will be one of the few scientific meetings ever devoted exclusively to this problem.

The day-long program will explore many facets of the subject, including causation, statistical importance, psychodynamics, treatment, and prevention. The audience will include physicians and other individuals with a professional or scholarly concern with suicide. For more details write to Leon Yochelson, M.D., Chairman of Psychiatry, George Washington University, School of Medicine, 901 NW 23 Street, Washington, D.C. 20037.

Further information on the program will be sent to you as soon as possible.

Sports Medicine Conference

A Conference on the Medical Aspects of Sports, sponsored by the American Medical Association, will be held in Philadelphia, at the Benjamin Franklin Hotel on November 28, 1965. The Conference is held annually in conjunction with the Clinical Convention of the American Medical Association.

This will cover a wide range of subjects of interest to physicians, especially those serving school and college sports programs. Included will be papers, panels, and discussions relating to readiness for sports participation, management of health problems in sports, and application of research to injury prevention. For further information, address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago 60610.

OBITUARIES

Dr. Frank Burchell

Dr. Frank Burchell died in Boston on May 27, 1965 at the untimely age of 49. Born in Paterson, he received his M.D. in 1943 at the Long Island College of Medicine. After interning at Columbia Presbyterian Medical Center, he did graduate work in orthopedics and served a residency at the New York Orthopedic Hospital. During the war, and later in the Korean conflict, he served as a medical officer in the Navy. He was a diplomate in orthopedics and was the "attending" in that specialty at the Valley Hospital in Ridgewood.

Dr. Benjamin J. Elwood

Installed on May 27 as president of the Hudson County Heart Association, Dr. Benjamin Elwood died four days later in a New York hospital. Born in Bayonne in 1910, he received his doctor of medicine degree at the University of Vermont in 1933. He did graduate work in cardiology and pulmonary diseases and was in private practice in his native city. He was president of the medical board of the Hebrew Home and Hospital, Associate Professor of Medicine at the New Jersey College of Medicine and Dentistry, and director of service at the Pollak Hospital. He was active in synagogue and civic affairs in Hudson County. He was the senior consultant in chest diseases at the Bayonne Hospital.

Dr. Thomas B. Protzman

Dr. Thomas Protzman, who was born in 1892, died of a ruptured abdominal aneursym on April 6, 1965. He served in World War I; and on being mustered out of the Army, he entered the medical school at the University of Nebraska in 1920—receiving his M.D. degree in 1924. He interned at the Englewood Hospital, which brought him to New Jersey, and he served the people of our state for the rest of his busy professional career.

He was team physician at the Dwight Morrow School in Englewood and was the first medical director of the Planned Parenthood Association of Bergen County. Dr. Protzman returned to the Army when his country needed him just prior to Pearl Harbor and was chief surgeon at Fort Monmouth. He then became the medical officer in charge of a troop transport and subsequently was transferred to the well-known hospital ship "Hope." Here Dr. Protzman was the medical officer in command, and saw duty all over the world. He was discharged from the Army as a full colonel and continued as a colonel in the reserve until his retirement.

Dr. George G. Reynolds

The Medical Society has just been informed of the death on November 4, 1964, of Dr. George G. Reynolds of Freehold. Dr. Reynolds was born in Pennsylvania in 1877 and received his M.D. at the University of Buffalo in 1908. In those days, relatively few doctors interned as it was the custom to go into private practice immediately on getting the degree. Dr. Reynolds, however, did serve an internship at the Buffalo General Hospital and then practiced in upper New York State. He then came to New Jersey where he founded and operated the Freehold Hospital and was also a surgical consultant at the Fitkin Memorial Hospital. He holds an award from the Boy Scouts of America for outstanding service to the community.

In 1958 he was a golden merit laureate of this Society. In his private practice Dr. Reynolds was a general practitioner with a special interest and skill in surgery. He was active in many civil affairs, was an official of his church, of the Masons and was a director of the Central Jersey Bank.

BOOK REVIEWS

Slim Down. George R. Rienzo, M.D. New York, 1964, Vantage Press. Pp. 167, illustrated. ($3.95)

This book has 167 pages. From page 15 to page 53 the author tells the story of the problems and physiology of obesity, the drugs and gadgets used in treatment. Most of the extra pages are taken up with black and white photographs of foods that do *not* have appetite appeal. The drawings demonstrating exercises are good. Emphasis of the book is on "will power" and the continuous use of a food scale. Nothing is said about how this "will power" can be accomplished. The readers would really have appreciated a chapter on "how will power" can be changed to "won't power." The proposition of weighing food before each meal is not a popular one. The volume is intended to teach the layman "good food habits." I can't conceive of a dieter who goes to business (and most people do) sitting down to a full course luncheon and a full course dinner twice a day. Diets should include the more plebian and readily available foods.

Much emphasis is placed upon cholesterol, which is still a controversial question. On the other hand, the recipes and calorie values in back of the book are good.

This is a nice little book: well written, it tends to clarify many of the facts and fallacies about weight reduction. However, it is, in sum, a rehash of what has already been written. The author has added nothing new from his own experiences in bariatrics

S. Wm. Kalb, M.D.

Better Health for Women. Charles Richard Alsop Gilbert, M.D. New York, 1964, Doubleday & Company, Inc. Pp. 365, illustrated. ($4.95)

This ambitious volume of over 350 pages provides a thorough but easily understood discussion of all sorts of health matters concerning the female. Following a general discussion of "The Healthy Woman," such topics are included as menstruation, pregnancy, dysmenorrheo, sex, childbirth, cancer of the uterus, and radiation. Each chapter is followed by a question and answer section which allows Dr. Gilbert to bring in the kind of questions patients are most apt to ask their physicians.

His directions for sex instruction for the girl by her mother are unusually direct and detailed, and possibly might not meet with complete acceptance by all physicians. It would seem to me that a mother who found the directions difficult to follow would discuss the matter with her own family physician who would be able to modify the instructions to suit the particular family.

The endocrine charts seem a little complicated but are separate from the text so that a lay reader could refer to them more frequently if desired. After reading the book, a non-professional woman commented that she was grateful for having so many details explained with such clarity. This is a fine book to recommend for intelligent patients. It will save the physician many hours of explanatory time. The type is easy to read, and there is a fairly complete index as well as a satisfactory bibliography and glossary. Laura E. Morrow, M.D.

A Mission in Action. Clarence E. de la Chapelle, M.D. and Frode Jensen, M.D. New York, 1964, New York University Press. Pp. 177. ($4.00)

Only recently has the regionalization concept entered the field of hospital administration. Many years ago, however, farsighted medical educators recognized that medical school faculty members might participate in graduate medical education programs in community hospitals. *Mission in Action* is the story of the regional hospital project of New York University. This decentralized plan extends the knowledge and skills of the faculty of a medical school to rural regions. This plan has met with considerable success; and it has been shown that where it was implemented, the quality of the care within the community was definitely improved. The New York University plan extended to such New Jersey hospitals as Fitkin Memorial, Monmouth Memorial, Hunterdon Medical Center, Mountainside, St. Joseph's, Hackensack, Passaic General, and the Hospital Center of the Oranges. This well written book is recommended to trustees, hospital administrators, directors of medical education, and all physicians serving community hospitals. It might well be used as a blueprint for planning and developing a regional medical education program. J. A. Rosenkrantz, M.D.

Textbook of Pediatrics. Edited by Waldo E. Nelson, M.D. with the collaboration of 85 contributors. Eighth Edition. Philadelphia, 1964, Saunders. Pp. 1,636. ($18.00).

This volume represents the efforts of many of the outstanding pediatric teachers and investigators of our time. Its editor, Dr. Nelson, has for the fifth time produced a new edition surpassing its predecessors in its cohesiveness and in the excellence of writing.

This reviewer is impelled, however, to raise a question which has long troubled him. If by "textbook" is meant an introductory coverage of pediatrics for medical students and other tyros, this volume is certainly not that. Its 1600 pages of fine-print text would make impossible demands on their visual abilities; its attempt to cover every possible ramification in the field of pediatrics goes far beyond their time and memory limitations. If on the other hand, this is intended to be a one-volume encyclopedia of pediatrics, one finds many inadequacies. Some subjects are exhaustively covered; others, many of considerable importance, receive scant attention. In no instance is a topic reviewed with that monographic completeness one expects in an encyclopedia. Many of the articles seem to be abbreviated versions of the same authors' excellent monographs.

To many pediatricians, the omission of steroid therapy in severe croup and laryngotracheobronchitis would seem regrettable. It is surprising to find no mention of sarcoid in the discussion of non-specific parotitis. The advice not to administer phenobarbital prophylactically after "febrile convulsions" would be questioned by many. It would seem important to indicate that the finding of albumino-cytologic dissociation may appear late in the Guillaine-Barré syndrome. And it might be pointed out that Macewen's sign can be elicited from other parts of the skull than the "sphenion" (the meaning of which I had to look up in Webster). But these and other examples which might be cited are few for a volume of this size.

While I must still question the exact place in modern medical literature of unwieldy and expensive books of this type, this *Pediatrics* is certainly the best of its kind to date. Clement E. Schotland, M.D.

The Liver and Portal Hypertension. Charles G. Child, 3rd., M.D. Volume I in the Series Major Problems in Clinical Surgery. Philadelphia, 1964, Saunders. Pp. 231, illustrated. ($8.50)

Here is an interesting account of the history of our knowledge of portal circulation. The book reviews current concepts of the pathophysiology of portal hypertension, discusses technical aspects of portal surgery, and outlines management of the major complications of an elevated portal pressure: esophageal varices, ascites, and hepatic encephalopathy.

An extensive experience at the University of Michigan is reviewed along with a discussion of the mechanism of portal hypertension, use and technic of splenoportography, precipitating factors in variceal hemorrhage, technics for portal decompression, choice of anesthesia, and the indications for prophylactic shunts. Ascites is discussed in several chapters. Present knowledge of hepatic encephalopathy is summarized. Also included is a discussion of the liver and protein metabolism. Experimental aspects of surgery and portal hypertension are presented in the final chapter.

As many books with multiple authorship, *The Liver and Portal Hypertension* suffers somewhat from repetition and occasional contradictory statements. From the viewpoint of the internist, greater attention to the role of medical therapy in prophylaxis and management of portal hypertension would have increased its value. The reversibility of portal hypertension with esophageal varices by medical therapy is acknowledged, but current theories of the mechanism for reduction of an elevated pressure by a medical regimen and difference in responsiveness in alcoholic and post hepatitis cirrhosis are not discussed. Also, in management of ascites complicating portal hypertension, the value of diuretic therapy, shunt surgery, and lymphatic cannulation are each reviewed separately. The uninitiated reader may fail to realize that most patients refractory to medical therapy are poor surgical risks.

This treatise admirably fulfills its purpose, "to bring the practicing surgeon an up to the minute report of basic concepts of technical approaches to important and controversial surgical diseases." It represents the most authoritative and up to date account of the problem of portal hypertension presented in a concise and lucid manner by distinguished investigators and clinicians. The printing and illustrations are of good quality. It is highly recommended for internists, pediatricians, general practitioners, and medical students, as well as surgeons who are confronted with an increasing number of patients with liver disease.

CARROLL M. LEEVY, M.D.

Current Diagnosis and Treatment. Henry Brainerd, M.D., Sheldon Margen, M.D. and Milton Chattin, M.D. Los Altos California, 1964, Lange Medical Publications. Pp. 869. (Price not stated)

Now in its third edition, this is an extraordinarily compact desk reference—practically a portable medical education. It covers a little of everything—psychiatry, pediatrics, otology, and so on, as well as general medicine. It includes tables of normal values, diagrams of artificial respiration, tabulations of drugs by generic and trade names, differential diagnostic charts, bibliographies, and detailed blue prints of technical procedures. As the publisher failed to indicate the retail price, we can't tell you if it is much of a bargain—but whatever it does cost, it certainly gives you a lot of book for your money. It should easily earn its keep on the doctor's desk. ULYSSES M. FRANK, M.D.

Doctor's Easaccount Record System: Disbursements and Income. Philadelphia, 1964, Saunders. Price: $9.50 the Set; Singly, Disbursements: $4.00; Singly, Income: $5.50.

The system is, as stated by the publisher, "an uncomplicated method of recording the income and disbursements of the average medical or dental practice" and can be utilized as "a ready-made system for the completion of income tax returns."

The Income and Disbursement Books are excellent ledgers for detail and ready reference. The directions given for use of the books are adequate and simple enough to be understood by even the novice bookkeeper.

Proper use of the books will provide desired figures at a glance: income—daily, monthly, annually—and disbursements—monthly, annually. The system should be a boon to doctors and their assistants who do not now have any organized method of recording income and expenses, and who, at the end of the year, find it a struggle to compile the required information for the tax return. EDITH L. MADDEN

The Adolescent in Psychotherapy. Donald J. Holmes, M.D. Boston, 1964, Little Brown. Pp. 337. ($9.50)

Dr. Holmes recognizes the special problems of the adolescent and the need for a new kind of therapist to treat him when he is disturbed. The author is convinced that neither the child specialist nor the adult specialist can adequately handle the "patient-in-between." *The Adolescent in Psychotherapy* is a highly readable book which deals with the problems, both normal and pathologic, of this age group. The text offers practical, realistic therapeutic recommendations.

The material in this book comes out of Dr. Holmes' eight years of experience with the all-adolescent service at the Neuropsychiatric Institute of the University of Michigan. One section of the text describes this Unit. This is most timely, since now many mental hospitals have started or are thinking of starting this kind of intensive treatment center. Under discussion here are problems which plague all of us working with disturbed teen-agers living together. The handling of such "anxiety producers" as running away, physical violence among the patient population, swearing, and stealing is discussed in a manner both down-to-earth and reality-bound. The book is remarkable for its freedom from psychiatric jargon. Dr. Holmes is so clear that there is rarely an instance where we do not fully understand what he says and why he says it.

Most of the author's recommendations and solutions to problems are new to the printed page, but not to those who have been working with this group of patients. We who work in the field are solaced to find here approval of and rationale for methods which we have been using but have never before formulated. This has been done for them in the excellent book.

LILLIAN L. WEINBERGER, M.A.

Massage Principles and Techniques. Gertrude Beard, R.N. and Elizabeth C. Wood, A.M. Philadelphia 1964, Saunders. Pp. 163, illustrated ($6.00)

The book is a "winner" and will be a valuable asset to any medical book list. The steps of the massage procedures are clearly illustrated through excellent photographs. Other features include a well-rounded bibliography for further reference and an impressive table of historical highlights in the development of massage.

MILTON E. CRAWLEY

School Health Education Study. Elena M. Sliepcevich, 1964, Samuel Bronfman Foundation. Pp. 74. Single copies available: Director, School Health Education Study, 1201—16th Street, N.W., Washington, D.C.

"Development of the integrated relationships between health and education, so vital to both, is a slow, and often frustrating process." So quoted Dr. Delbert Oberteuffer of Columbus, Ohio, in his foreword to this precise and basic investigation of the problem of school health education. The scope of such education is broad, covering such areas as the nature of disease, effects of radiation, behavioral aspects of accident prevention, an understanding of health and medical care programs, significance of international health programs, selection of health products and services, environmental hazards in air and water, community health services, foundations of mental health, and preparation for marriage and parenthood.

This summary report of the School Health Education Study was prepared by sixteen national individuals representing public health, medicine, school and college health education, and educational administration. It included a sampling of the methods used in large, medium, and small communities, representing 35,000 school systems and 35,000,000 school children. The study showed that only one-half of the school systems had any health education program. It further found that there was much variation in the material presented and an even greater variation in what the children learned from the material. And there was much controversy about who prepared the material and who was to teach it.

This report provides excellent material for medicine and education to assess what we are doing at state and community levels. It also offers solid backing for the newly formed association of school physicians to chart a new course for their activities. The school physician can help in formulating the materials and methods of presenting the problem of school health education.

The report committee promises a further project which will provide experimental curriculum materials for health education. ROBERT E. JENNINGS, M.D.

Textbook of Otolaryngology. D. D. DeWeese, M.D. and W. H. Saunders, M.D. Ed. 2. St. Louis, 1964, Mosby. Pp. 523 with 405 illustrations. ($9.25)

Interest is immediately drawn to this textbook by dedication to two of America's greatest, Drs. A. C. Furstenberg and the late James H. Maxwell. It is a very timely edition and accomplishes what it aims to do. Not only is it very informative and up to date as a reference for general practitioners, but also for beginning otolaryngologists. Because of the great and extensive progress in this field of medicine and surgery, it was necessary to bring the profession up to date: this it has done.

The editing makes for good clarity and ease in reading. In addition, the chapters on physiology of hearing are very elucidating. Two chapters are outstanding, for which otolaryngologists should be both grateful and interested. They are the fine chapters on speech disorders and the other is the section on salivary gland disorders.

It is a well written and edited book worth possessing. WILLIAM SCHWARTZ, M.D.

Physical Examination of the Surgical Patient. J. Englebert Dunphy, M.D. and Thomas W. Botsford, M.D. Third Edition. Philadelphia, 1964, Saunders. Pp. 396, illustrated. ($8.50)

This third addition of Dunphy and Botsford offers to the student and practitioner a textbook strictly for surgical-physical examinations. The examination of a thorax with percussion and auscultation still dominates the student's hour of instruction. This text presents a skillful and thorough examination of the abdomen. The book is not meant as a textbook of surgery, nor as a short cut to surgical diagnosis.

This edition is generously illustrated with new photographs and old line drawings. It includes entirely new chapters in cardiac surgery and burns, with a special section on emergency resuscitation.

The book opens with some points in history-taking, evaluation of symptoms, especially those of pain, and the other frequent surgical presentations. The text is then divided into regions of the body. Examination of these parts in detail is presented. It is thorough, practical, and of particularly great value to the medical student and young practitioner. It dramatizes in concise form many of the frequently encountered surgical conditions.

It cannot be too highly recommended for hospital libraries. DANIEL F. FEATHERSTON, M.D.

A Marriage Manual For Catholics. William A. Lynch, M.D. New York, 1964, Trident Press. Pp. 357 ($4.95)

A Marriage Manual for Catholics is a complete, practical guide to marriage, written by a prominent Catholic physician. Dr. William A. Lynch speaks frankly yet factually of every basic subject concerned with marriage, from early dating to death. His inclusion of such topics as alcoholism, menopause, adoption, and miscarriage adds a comprehensive view of problems as well as compensations often neglected in manuals of this nature. His language is simple and interesting, though soundly based in the medical authority of a practicing obstetrician and gynecologist. Dr. Lynch provides easy, refreshing, accurate information on subjects often mishandled in sex manuals today. His book may well be recommended to those married as well as those contemplating marriage, to Catholics and non-Catholics alike. LEON P. NUTZEL, M.D.

Medical Pharmacology. Andres Goth, M.D. St. Louis, 1964, Mosby. Ed. 2. Pp. 585 with 57 illustrations and charts. ($11.75)

Much of pharmacology has little direct meaning to the medical practitioner. Goth's volume, on the other hand, is focused sharply on the needs of the clinician and medical student. This edition is up to the minute and covers recently introduced drugs. The book is cluttered somewhat by structural formulae which do not interest the average practitioner. However, in his discussion of safety and effectiveness, the author uses clinical criteria and does not refer simply to animal experiments. In addition to material on pharmacology in general, there is a brief chapter on prescription writing, emphasizing the modern rather than the traditional approach to this fast decaying art. The body of the book is taken up with chapters divided by pharmacologic effect—anesthetics, diuretics, steroids, and so on. On the whole, this is a readable and thoroughly up-to-date handbook of applied pharmacology. VICTOR HUBERMAN, M.D.

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File: Diarrhea

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1. Beaser, S. B.: J.A.M.A. 187:887, 1964. 2. Marble, A.: Appl. Therap. 5:614, 1963. 3. Moss, J. M. et al.: Med. Times 92:645, 1964. 4. Linder, M. et al.: New York St. J. Med. 62:337, 1962.



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Each 30 cc. contains: Kaolin, 6.0 Gm.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Sodium benzoate (preservative), 60 mg.; Alcohol, 3.8 per cent.

references: 1. Winfield, I. W.: Am. J. Gastroent., 31:438, 1959. 2. Blanchard, K.: Rocky Mt. Med. J., 54:527, 1957.

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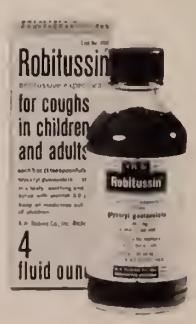
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See product literature for
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*Boyd, E.M., and Ronan, A.K.: Am. J. Physiol., 135:383, 1942.

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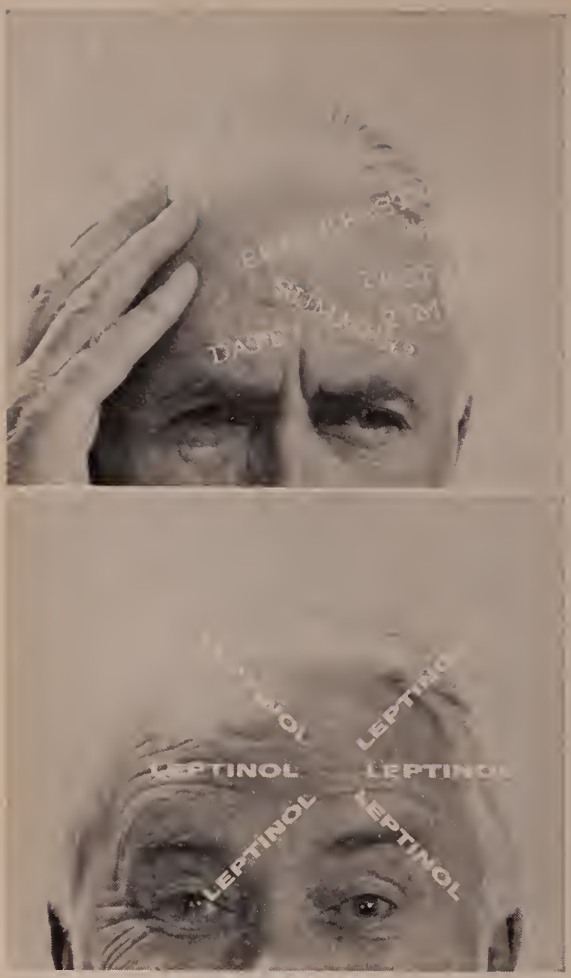
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For full information, see your Squibb Product Reference or Product Brief.

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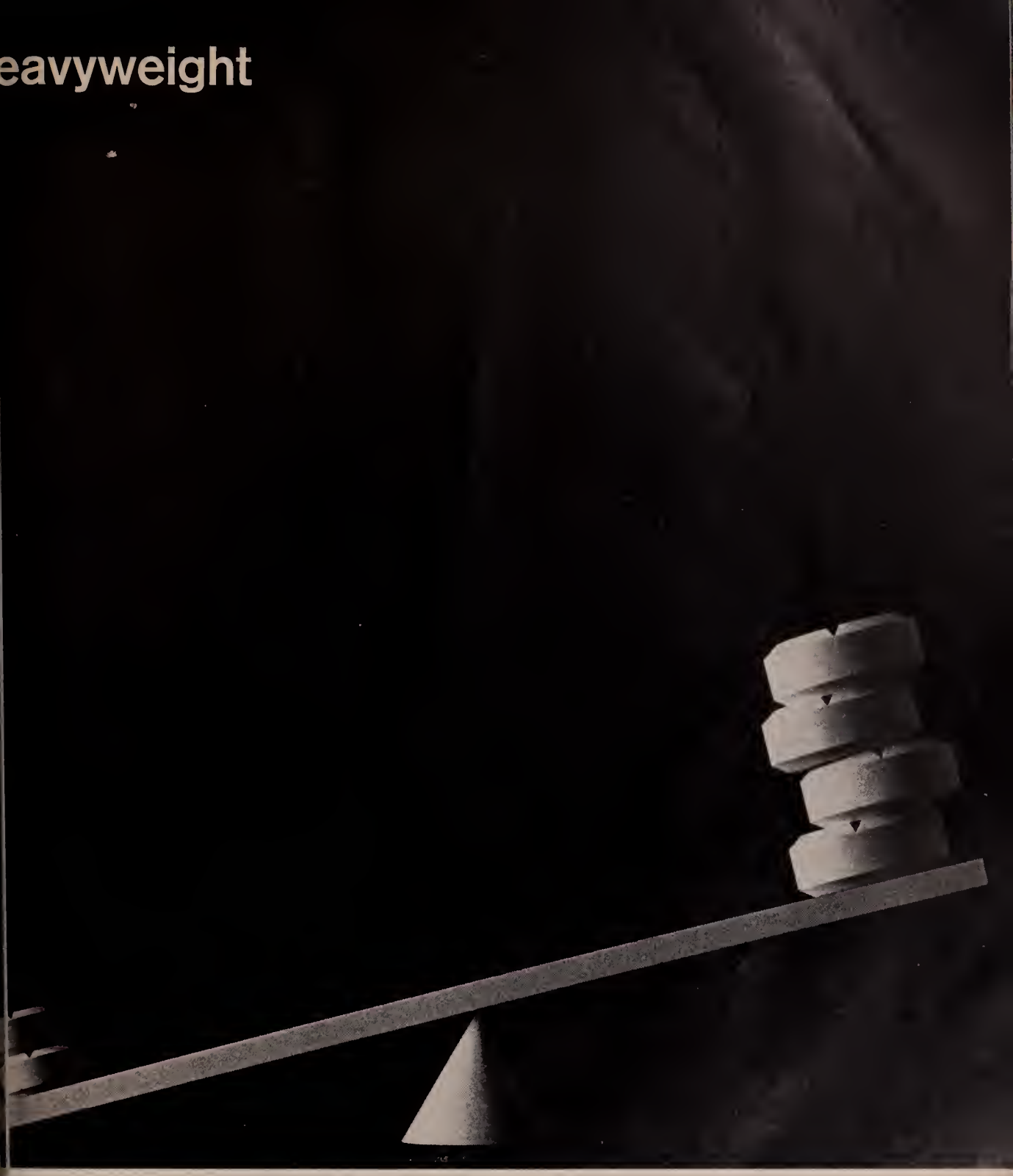
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Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
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Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Swartz, C., et al.: Circulation 28:1042, 1963.

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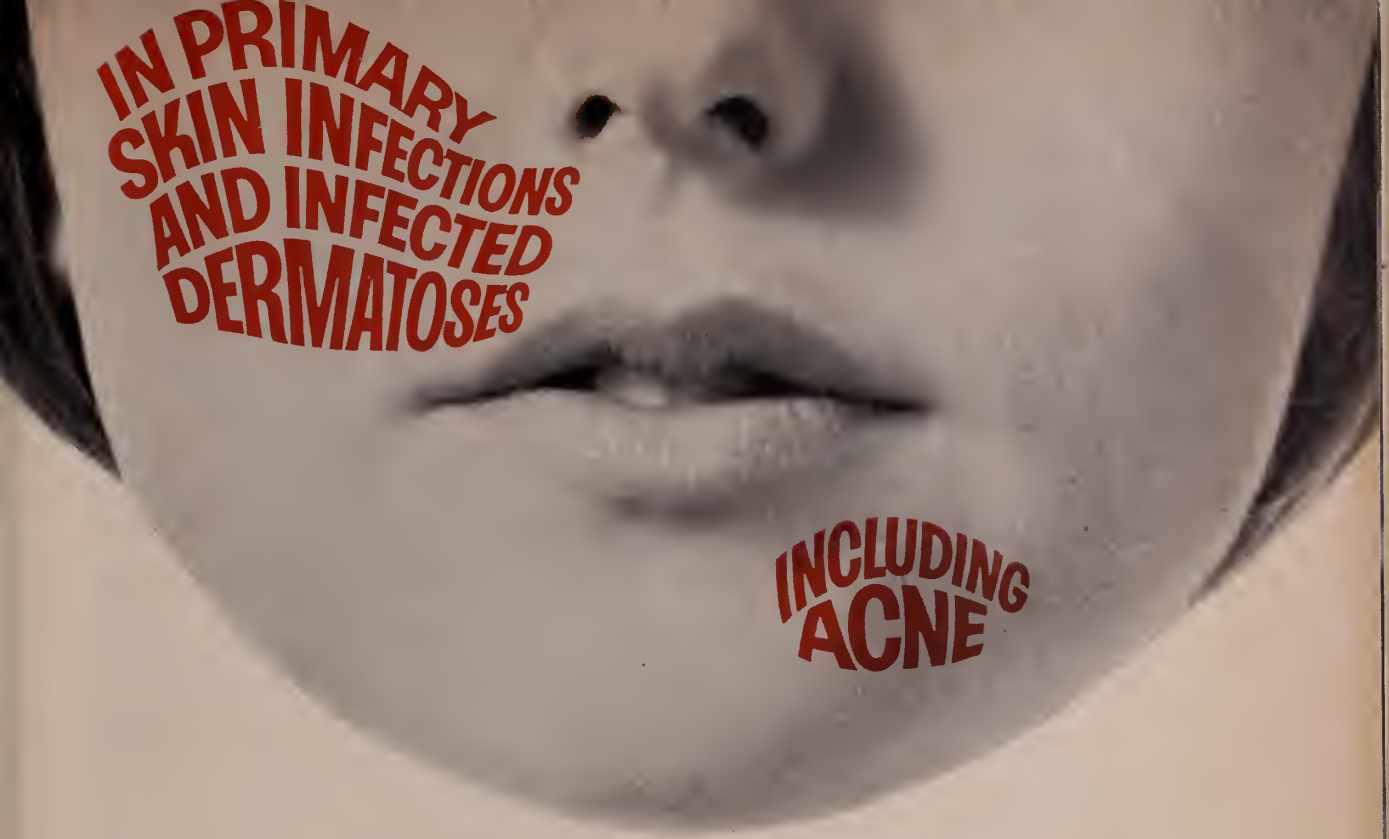
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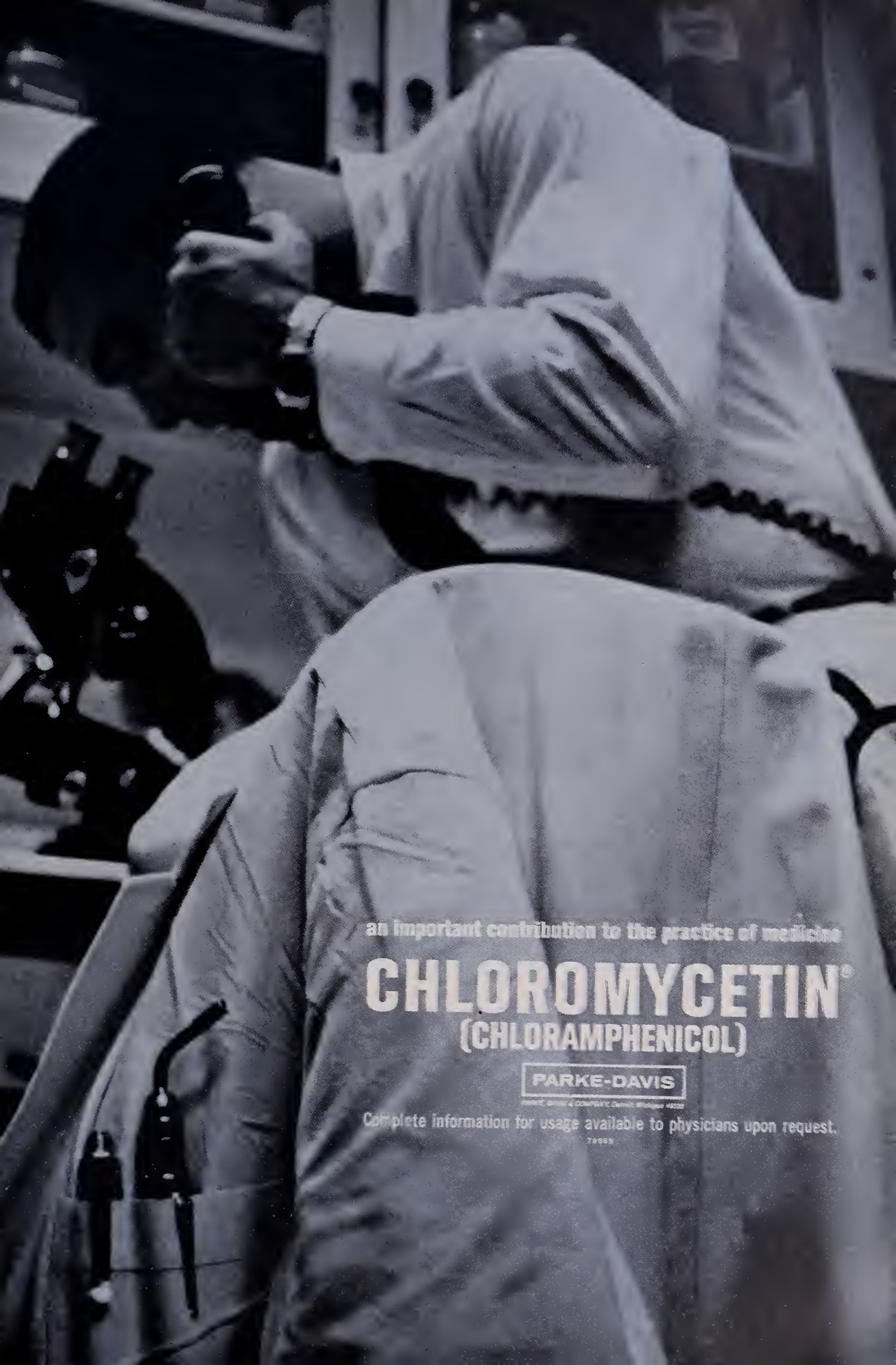
The Course consists of 34 two-hour sessions given weekly on Wednesday mornings, 9 to 11, in the Hospital Auditorium. The lecturers are outstanding members of several metropolitan medical faculties, chiefly of New York City and Philadelphia. Ample opportunity is given to discuss with the speakers clinical problems arising in the care of individual patients. Detailed notes of each lecture are also distributed to physicians attending the Course.

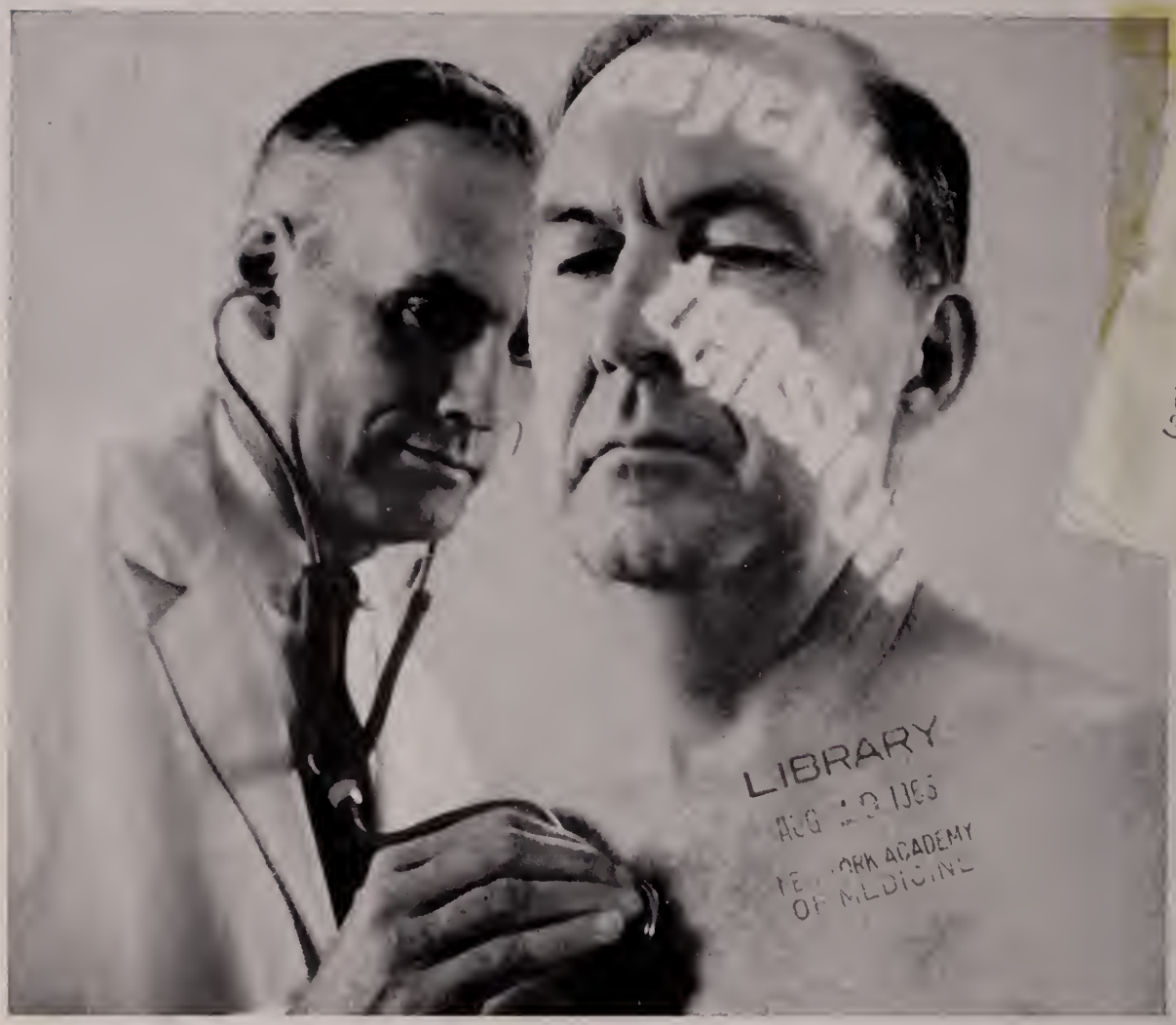
The 1965-1966 Course will be divided into sections dealing with *Endocrinology and Metabolism, Kidney and Electrolytes, Heart and Circulation,* and *Disorders of the Respiratory Tract.* Particular emphasis will be laid upon therapeutics as well as on the basic physiologic and diagnostic problems involved.

The opening session is scheduled for Wednesday, Septembr 22, 1965. IF YOU ARE INTERESTED IN ENROLLING AND HAVE NOT RECEIVED AN APPLICATION FORM, IT IS IMPORTANT THAT YOU WRITE IMMEDIATELY TO THE CHAIRMAN OF THE COURSE, DR. S. E. MOOLTEN, MIDDLESEX GENERAL HOSPITAL, NEW BRUNSWICK, N.J. The fee for the entire Course (34 sessions) is $125 (for Fellows of either Academy the fee is $110; for interns and residents $35).

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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal of hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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September, 1965 Vol. 62, No. 9

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Warning: If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

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These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

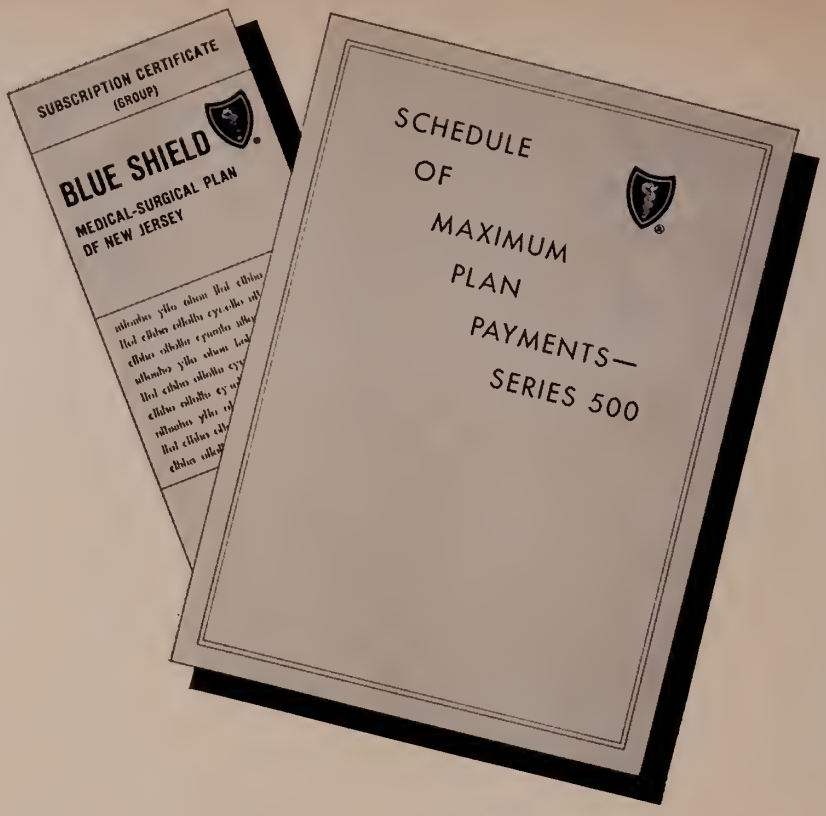
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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

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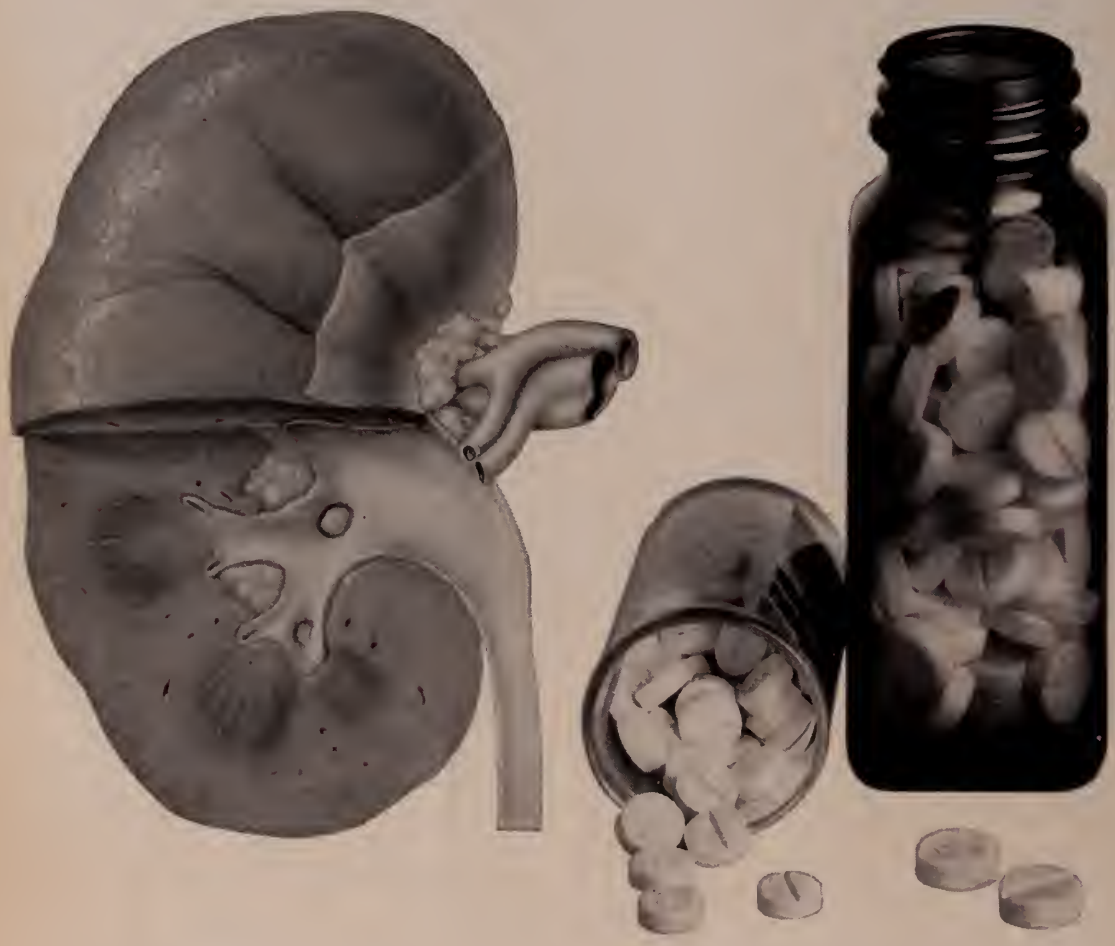
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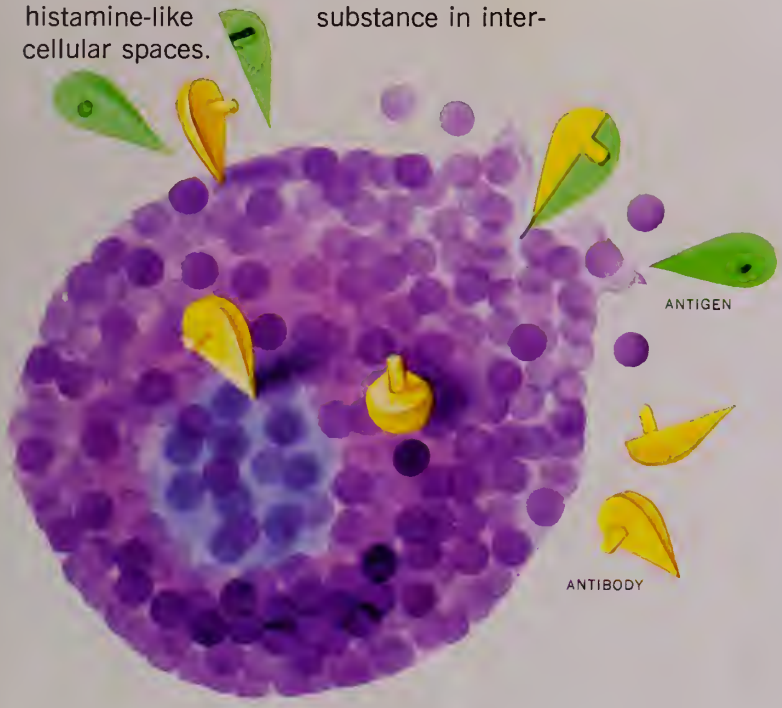
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in theory, allergy begins like this:

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*Schiller, I.W. and Lowell, F.C.: New England J. Med. *261*:478, 1959.

BRIEF SUMMARY: *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness. *Side Effects:* Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Other dosage forms available:* conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

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It has been noted that low-back disorders frequently "... are caused by truly mechanical conditions which yield to conservative treatment."[1] Basic to this conservative treatment are bed rest, a board for the bed, and applied heat. In addition, a good muscle relaxant is often helpful, as "... muscle relaxants are useful in chronic as well as acute low backaches."[4]

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REFERENCES: 1. Soto-Hall, R.: Med. Sci. *14*:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See Medical News: J.A.M.A. *185*:39 (July 13), 1963. 3. Gordon, E.J.: Med. World News *5*:54, 1964. 4. Cozen, L.: GP *26*:82, 1962. 5. Larson, C.B.: Postgrad. Med. *26*:142, 1959. 6. Forsyth, H.F.: J.A.M.A. *167*:163, 1958. 7. Weiss, M., and Weiss, S.: J. Amer. Osteopath. Ass. *62*:142, 1962. 8. Rowe, M.L.: J. Occup. Med. *2*:219, 1960.

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Thanks to the unique Gradumet, both drugs are released in an effective dosage ratio, **minute by minute throughout the day.** The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract. **The release is continuous and controlled.**

It's this predictable release that makes the difference for your patients. Dosage is just once a day.

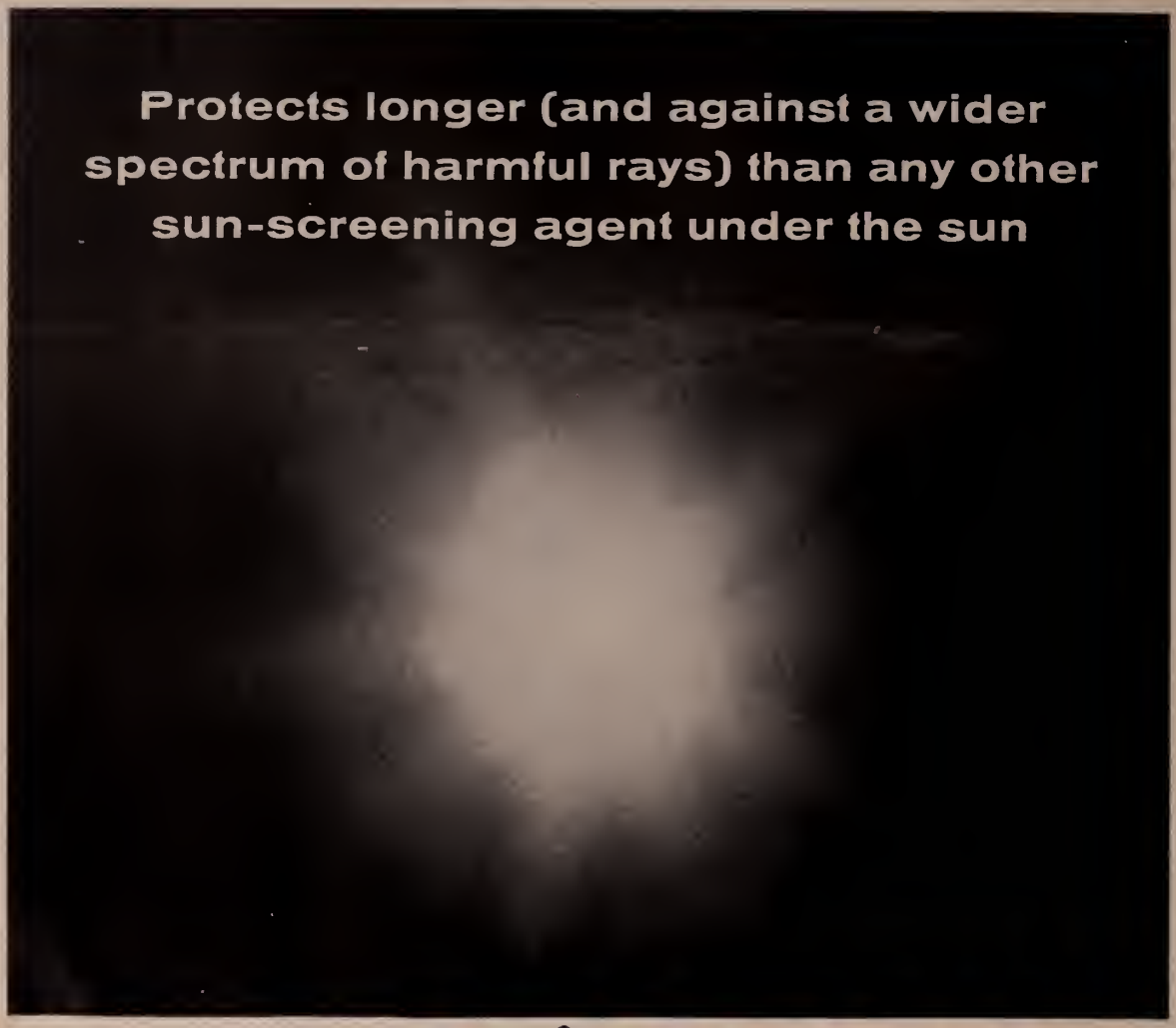
PRECAUTIONS: Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or those sensitive to ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

DESBUTAL® Gradumet®

Desbutal 10—10 mg. Methamphetamine, 60 mg. Pentobarbital.
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Clinical studies show that many drug-induced photosensitivities are initiated by solar rays longer than 3200 Å. Most commercial lotions absorb *only short, burning rays up to about 3100 Å.* New UVAL provides excellent screening of short, erythema-causing waves *and* sustains high effectiveness throughout the photosensitizing spectrum (up to 6500 Å). Moreover, laboratory studies in humans demonstrate that UVAL protects *hours longer‡* than any other sun-screening agent available. Such protection is unprecedented. UVAL has no known contraindications and is cosmetically acceptable. Literature (including a list of photosensitizing agents) and samples available on request.

‡As long as UVAL remains on the skin

Distributed by Stuart **THE STUART COMPANY,** Pasadena, California
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*10% 2-hydroxy-4-methoxybenzophenone-5-sulfonic acid

a working analgesic for the working arthritic



Arthralgen® rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. Combining two better-tolerated, time-tested analgesics, acetaminophen and salicylamide, into a pharmacologically sound and therapeutically effective formulation, Arthralgen relieves pain rapidly with less likelihood of gastric irritation than aspirin.

in maintenance therapy . . .

Because it contains no sodium, Arthralgen is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.[1]

Arthralgen®

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.

Arthralgen®-PR

(Arthralgen with prednisone 1 mg.)

BRIEF SUMMARY:

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chickenpox or susceptible persons exposed to it.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953.

A. H. ROBINS COMPANY, INCORPORATED RICHMOND, VIRGINIA



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



NTZ Nasal Spray relieves hay fever symptoms on contact

Fast symptomatic relief from seasonal hay fever comes in the convenient NTz Nasal Spray bottle. Two sprays quickly relieve itching and decongest the nasal membranes on contact. The first spray of NTz shrinks the turbinates, helps restore normal nasal ventilation and breathing. After a few minutes a second spray enhances sinus ventilation and drainage.

NTz Nasal Spray reduces excessive rhinorrhea without unpleasant dryness. It is well tolerated by delicate respiratory tissues. NTz also provides relief in head colds, perennial rhinitis and sinusitis.

NTz's carefully balanced formula relieves three ways: with a decongestant, a topical antihistami and an antiseptic wetting agent.

Neo-Synephrine® HCl 0.5%, a decongestant of unexcelled efficacy to shrink nasal membranes.

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NTz is supplied in leakproof, pocket-size, spray bottles of 20 ml. and in bottles of 30 ml. with dropp

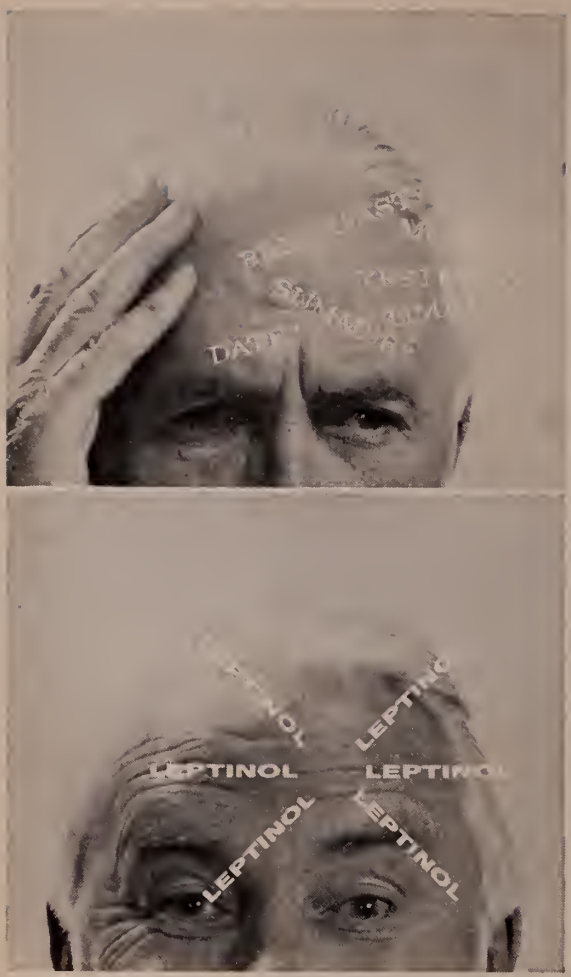
Winthrop Laboratories, New York, N. Y. 10016

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Hay fever... a summer hazard prescribe NTZ® Nasal Spray



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When elderly patients display symptoms of apathy, mental confusion, memory lapses... consider LEPTINOL

Leptinol is a useful medication that deters senile mental deterioration by stimulating the cerebral vasomotor and respiratory centers . . . increasing pulmonary ventilation and the supply of blood and oxygen to the brain.

Non-addicting Leptinol also is valuable in long-term treatment, since patients do not establish a tolerance.

Each LEPTINOL bi-layer tablet contains: PENTYLENETETRAZOL, 100 mg., NIACIN, 50 mg., THIAMINE HYDROCHLORIDE, 1 mg., ASCORBIC ACID, 20 mg. DOSE: one or two tablets, 3 times daily. Leptinol produces such a sense of well-being, patients should be cautioned not to exceed recommended dose which offers maximum effectiveness.

Side Effects:—overdosage may produce tremor, convulsions or respiratory paralysis.

Caution should be taken when treating patients with a low convulsive threshold.

Write for detailed literature and starter Leptinol doses.

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Pharmaceuticals — Allentown, Pa

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

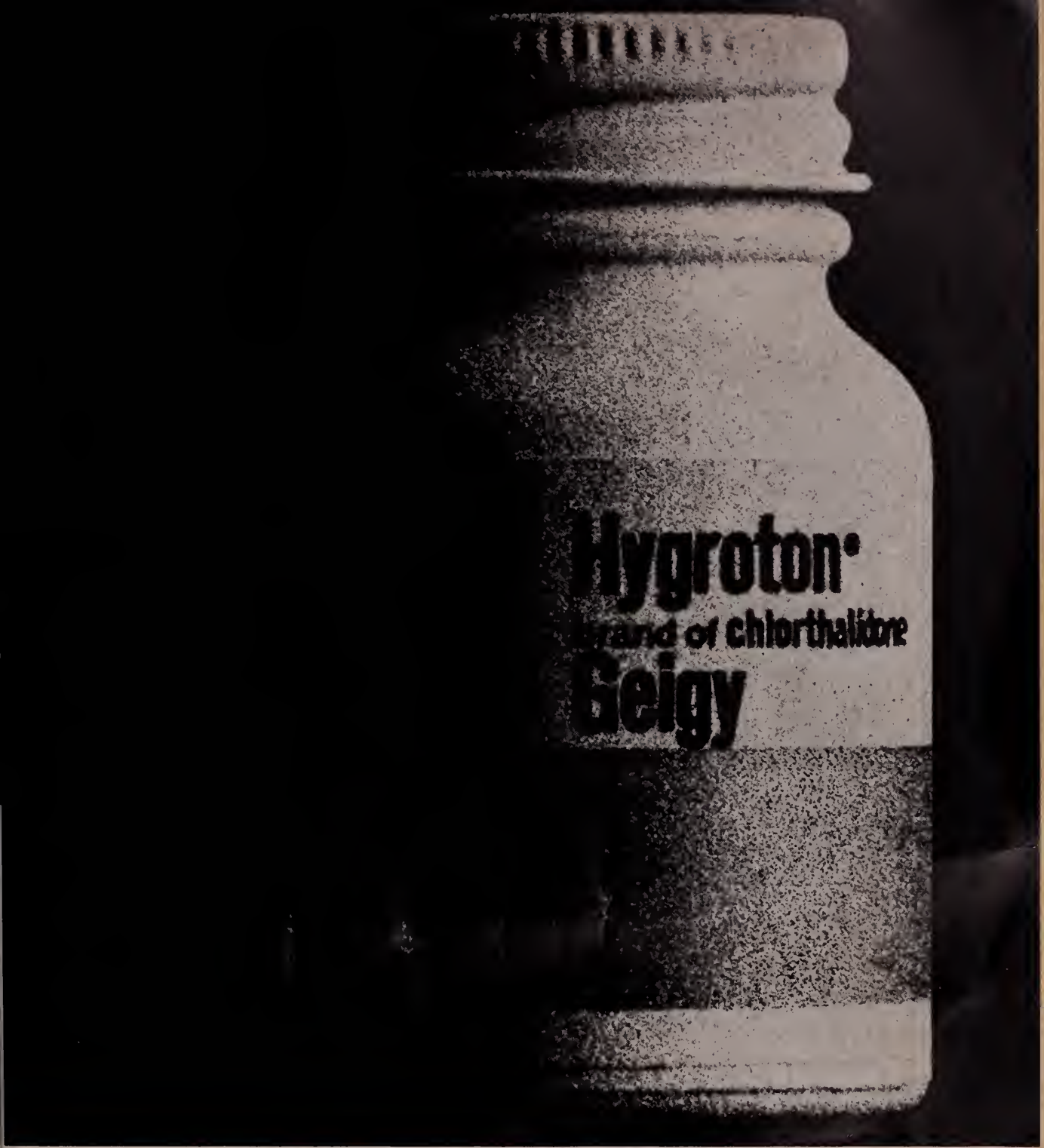
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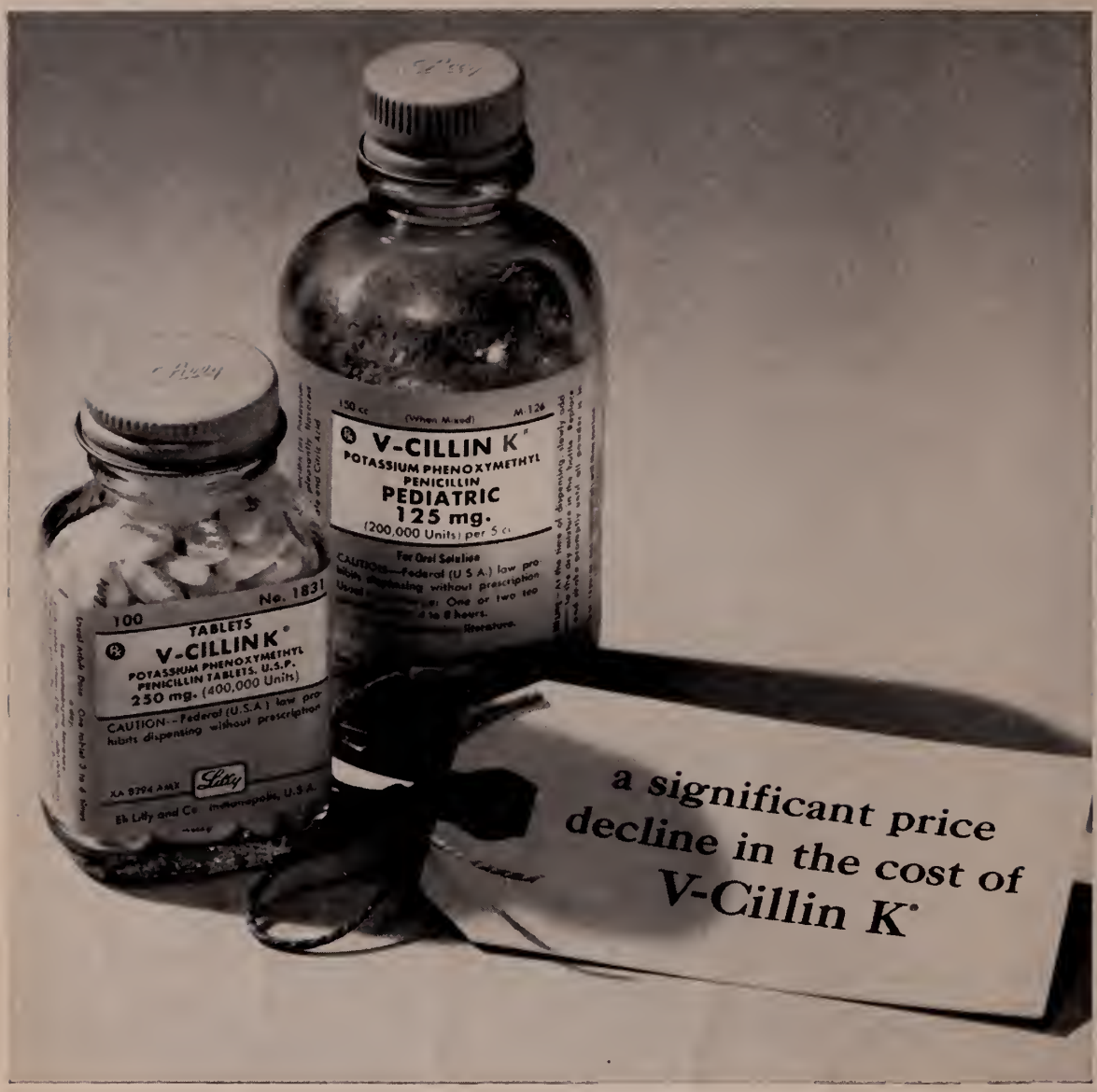
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Patients you want to bring to dry weight.
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V-Cillin K now costs approximately 21 percent less. This significant price decline constitutes a substantial saving and still offers these important benefits over penicillin G:

The effectiveness of intramuscular penicillin. Just three 250-mg. doses daily provide total twenty-four-hour penicillin blood levels equal to those achieved by injection of 600,000 units of procaine penicillin G. A fourth dose increases daily penicillemia to levels 35 percent above those achieved by injection.

Consistent dependability—even in the presence of food. Comparative pharmacologic data show that V-Cillin K produces peak blood levels *twice* as high as those of penicillin G, with *half* the dose.

New, thin coating . . . new size and shape. The new coating eliminates the characteristically bitter taste of oral penicillin and makes V-Cillin K tablets easy to swallow. The new shape makes them easy for physicians and pharmacists to identify.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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EDITORIALS

Medicine's Ultimate Boss

Some of our critics these days take the position that the physician is, ultimately, an agent of Society (with a capital S), who should be subject to the controls of that same Society. The argument runs that doctors insist on policing their own profession, that they resent any kind of nonmedical control, and that they forget, in the last analysis, that they are servants of the People (capital P) who have licensed them, who patronize them, give them their privileges and, to a large degree, finance their education. (One of the reasons for supporting AMA-ERF, incidentally, is that it will lessen the medical students' indebtedness to society generally if the medical profession assumes more of the cost burden of medical education.)

The critics are battling a straw man. As much as we may dislike it, the fact is that when the chips are down, we are all subordinate to lay authority. We are licensed by a Board of Medical Examiners, but the Board is appointed in most states by a Governor who is not a physician. Our hospitals are, ultimately, controlled by lay Boards, on which physicians rarely sit. This is part of the democratic American tradition. We don't put teachers on a Board of Education; and, in our country at least, the Secretaries of the Army and Navy are neither Generals nor Admirals. A police commissioner is rarely a professional policeman and ditto with the civilian head of a large fire department. There is, one suspects, a deeply ingrained American fear of a tyranny of experts. Basically under lay control—at least at the policy level—are medical schools, hospitals, medical research agencies, health insurance plans, and even, in many cities, public health departments. The organizational division, actually, is a sensible one—with operating responsibility in professional hands, while policy decisions flow from representatives of the public. Our critics are tilting at windmills. We have always recognized our responsibility to Society and to its chosen representatives.

What's Ahead in Medical Education?

A brave new world, according to the report* submitted earlier this year by Dr. Lowell T. Coggeshall to the Association of American Medical Colleges. From a reading of this document, one concludes that medicine's educational future will be characterized by at least twelve new approaches:

1. Medical education must be university-based. In the USA there are still 9 medical schools unaffiliated with universities. And some that consider themselves university schools are, in fact, quasi-autonomous rather than organic parts of the universities. Dr. Coggeshall finds this deplorable.

2. Medical education must be oriented to research as much as to practice.

3. The training of interns and of residents in the specialities should be a function of university medical schools rather than a responsibility of hospital staffs.

4. Fewer and fewer doctors will become general practitioners.

5. Solo private practice will decline in favor of group, academic, or hospital practice.

6. Because of advances in laboratory medicine and instrumentation, less emphasis in medical education should be placed on diagnosis by way of the doctor's own senses.

* Planning for Medical Progress through Education: A Report Submitted to the Association of American Medical Colleges by L. T. Coggeshall, M.D., Evanston, Illinois, April 1965, Association of American Medical Colleges, 2530 Ridge Avenue, Evanston, Illinois 60201.

7. University hospitals will become referral institutions, where serious illness will be sent for differential diagnosis, while (presumably) community hospitals will take care of trivial illnesses (and, one supposes, chronic disabilities, too).

8. In medical education, emphasis will shift from "accumulation of facts . . . to a better understanding of the mechanisms involved in normal tissues and their diseased states."

9. Less attention will be paid to devoted personal care and more to scientifically based treatment; thus, "the modern physician with limited amounts of penicillin can accomplish more with a pneumonia patient than could the doctor of two decades ago who devoted many weeks of constant care to his patient. No amount of attention insured recovery."

10. More medical practice will be hospital-based than ever before. "The patient in a department-store-dominated age is unable to perceive the desirability of shopping around for health care, of leaving blood and urine samples in one place, than visiting another physician to have an x-ray, then returning to the original doctor's office to learn the outcome."

11. The team will dominate the individual practitioner. Dr. Coggeshall phrases it this way: . . . "The concept of medicine as a single discipline . . . should be replaced by the concept of the health professions working to increase the health of society as well as the individual. The physician must collaborate with social scientists, economists, community planners, anthropologists, social psychologists, engineers, and a host of others to provide the entire range of therapeutic and preventive measures."

12. The M.D. degree will be considered the middle rather than the end of a doctor's formal training. "Professional education (of the doctor) will continue (beyond the M.D. degree) in an ordered sequence under sponsorship of university medical schools through interneship and residency programs."

That's the way the picture looks according to a committee of distinguished scientists, headed by Dr. Coggeshall and including Dr. Michael DeBakey, Dr. Robert Berson, Dr. George Perera, Dean Deitrick of Cornell, Dean Hubbard of the University of Michigan, and Dr. Clark Kerr, president of the University of California.

A True Helping Hand

New Jersey's unique helping hand organization for doctors' families is the Society for the Relief of Widows and Orphans of Medical Men. At its last Annual Meeting, May 1965, our House of Delegates adopted the following resolution, which is called to the attention of all our members. Note especially the last paragraph.

Send your applications to Box 95 in Belleville.

Whereas, The Society for the Relief of Widows and Orphans of Medical Men of New Jersey has been in existence for eighty years, and during this period of time, has provided for the care and protection of widows and orphans of deceased members; and

Whereas, physicians have taken care of their own who were in need of assistance, and should continue to do so; and

Whereas, there is a continuing need for relief, assistance, encouragement, and protection of widows and orphans of medical men of New Jersey who are in difficult circumstances; and

Whereas, The Society for the Relief of Widows and Orphans of Medical Men of New Jersey is the only organization of its kind in this State, the same being patterned upon the original Society founded in London, England in the early seventeenth century; therefore be it

RESOLVED, that The Medical Society of New Jersey urge and recommend that all its members actively participate in the work of The Society for the Relief of Widows and Orphans of Medical Men of New Jersey by becoming members of this Society, thus helping their own families and the families of their brother physicians; and be it further

RESOLVED, that members of The Medical Society of New Jersey be informed through THE JOURNAL that applications and information may be obtained by writing: The Society for the Relief of the Widows and Orphans of Medical Men of New Jersey, P.O. Box 95, Belleville 9, New Jersey.

ORIGINAL ARTICLES

Based on 20 years of field experience, as a high school physician, Dr. Tomlins has prepared this useful little monograph.

Football Field Injuries

Their Immediate Management

Francis I. Tomlins, M.D./Ridgewood

Athletes are young; they are physically fit; they have at least normal healing factors; and usually, they are well motivated to return to the field of play. A trained and conditioned youth will respond rapidly to early and specific treatment.

The purposes of this article are to supply coaches, trainers, and physicians with a guide for interpreting football injuries on the field and to offer an immediate treatment plan for these injuries.

Football injuries require immediate diagnosis. Here are the questions to be answered quickly. Where is the area of injury? Is there a cranial or spinal injury? Is the player unconscious? What is the condition of the eyes? Are there respiratory difficulties? Where is the tongue? How much pain is present? Does the player have abrasions, lacerations, swelling, or bleeding? Is there an abnormal position or deformity of the injured part? Is there normal range of motion? Does he have abdominal or groin injury? Can he stay in the game or must he leave the field? And above all, how is the injured player to leave the playing field? If there is doubt, the athlete must be removed immediately from play to evaluate his injury. The three proceduces needed to evaluate the injury are:

1. History: Give him time to relate his experience before asking major questions. You want to know the mechanics of the injury. Was there a blow? Did he fall? Was there a twist? What did he hear—such as a click, pop or crack? What type of pain? Is it dull, sharp, or constant? Does it remain in one place or does it travel?

2. Inspection: While he is answering, look at him thoughtfully. Do you see a bruise or wound? If he has a deformity, compare it with the uninjured part of the body. Pay attention to *the way* he points to his injury. If he places his full hand over the area, this suggests a large area of injury. If he points with a finger to the injury, he is localizing it for you. Look at his eyes while he is talking. Eyes will register pain even though he attempts to minimize his injury to you.

3. Palpation: Gently feel the injured area. Do not jerk or pull. Do not force unnecessary movement. Since you must locate the injured area, tell him it might hurt. Usually, tenderness locates the site. Feel for swelling and deformity. If you feel a peculiar sensation (as if air or crumbly paper is under the skin), think of crepitus: a sign of fracture. Generally there must be a full range of motion without severe pain before the athlete may return to the scrimmage or game.

Head Injuries

A history of repeated concussions is disqualifying for any contact sport, especially football. Specifically three "minor concussions" will disqualify an athlete from ever playing football. Each coach must keep a "book" on each player who has a history of a concussion or skull fracture so that no one will be sent in to play if he has had three concussions.

Minor Concussion: Class as a minor concussion the frequently seen condition with no loss of consciousness but with amnesia for some period of play. This youth must be removed immediately from play and checked by the doctor. The coach must accept the fact that he has lost this athlete until he has been returned to active play by the physician.

The athlete must then have a skull x-ray. He is observed daily on the field and is not permitted to have any contact for seven days. Place a "golden shirt" (any bright, different colored shirt than the practice jersey) on him

and permit him to run through plays in scrimmage. But he absolutely cannot be touched by any other player. This can be done well and safely with quarter-backs and ends; safely with half-backs; with more care, a fullback and not very well with linemen; and not recommended at all for defensive linemen and linebackers. If the seven days should include a game day, then he sits on the bench that day.

Hysterical Minor Concussion: This occurs only on game day and almost never when the team has a commanding lead. A player misses a tackle that would have prevented a touchdown and following this, has a period of hysterical amnesia. I consider this a "concussion," as he may have sustained a head injury while fighting off blockers. This type of concussion is managed exactly as stated above for "minor concussion."

Conscious Concussion: In this case the athlete has not been unconscious and has no amnesia. But he complains of severe headache and when he looks upward, becomes dizzy. This athlete should be placed under immediate medical supervision and x-rayed. When he is returned to play, he should be managed as stated under "minor concussion."

Major Concussion: Here there is a period of unconsciousness, from a few seconds to many minutes. Under no circumstances should this athlete be unattended by a physician. The player must be x-rayed and placed under medical observation, preferably the care of his family physician.

When this youth has been allowed to return to the athletic field, do not permit contact in any manner for three weeks. He runs and maintains his condition, but that is all. After this period of three weeks, if no complications have arisen, he may resume play.

If the unconsciousness has exceeded ten minutes, he is not permitted to play football for the rest of the season.

If the unconsciousness has gone into hours, he should be through with football for life.

Skull Fracture: A history of skull fracture would be a disqualifying defect unless it was not complicated by blood clots or hemorrhage. When dealing with an unconscious athlete, always check the pupils. Unequal pupils indicate a severe head injury. The athlete must be removed by stretcher immediately to a hospital.

If a skull fracture occurs on the football field, that athlete should never again play football.

Remember: An unconscious athlete may also have a neck injury.

Possible Fracture or Dislocation of the Cervical Spine: Give the athlete time to answer your questions. Does he have a pain or stiffness in his neck? Is there any numbness or tingling sensation in his arms or legs? Can he move his arms and legs? Is there any numbness about his waist? If he answers "yes" to these questions, assume provisionally that he has spinal cord injury. Leave his helmet on. If you take it off, it will allow his head to fall backward as his shoulder pads keep him from being flat on the ground. He must be removed *by stretcher* to the hospital. Someone must hold his head firmly in a straight axis, to avoid any flexion or over-extension of his head or neck. Remember, we have all the time we require on the field of play, if the injury warrants it.

"Pinched Nerve" or Lateral Neck Strain: In this common injury, the athlete usually complains of severe hot burning pain in the center of his shoulder, with numbness and tingling to burning sensation down his shoulder, arm, forearm, and fingers, accompanied with neck pain on the affected side and with or without inability to move his arm. This injury is usually caused by a blow on the side of the head. It may disappear in a few minutes or persist for many hours.

If it appears mild and clears up rapidly, he may be allowed to return to the game; if severe, he is removed from play and should be x-rayed. All such players on returning to play should be fitted with a neck collar to restrict the neck movements.

Stiff Neck or Wryneck: This frequent injury is due to strains to the posterior neck muscles. It can be mild showing only local tenderness; or be severe with muscle spasm. If it has *not* been accompanied by a bruise or hematoma, hot packs, enzymes, and rest are indicated. If you suspect a hematoma, cold packs and enzymes are recommended, followed by hot packs until recovery. A neck collar is desirable when he returns to play. An athlete with a long neck should not play football unless he has been fitted with a neck collar. The stocky, bull necked individual is usually *not* subject to neck injuries. Extensive neck conditioning exercises are important procedures to prevent neck injuries.

Facial Injuries: Today, due to the improved head gear, face guards, and dental mouth pieces, injuries to the face are infrequent and dental injuries almost negligible. The only mouth injuries I have seen in five years were soft tissue damage to the mouth due to the athlete not wearing his mouth piece. We still see broken noses due to the fact that feet and hands do slip through the face guards. The coach must constantly check on the position of the face guard to make sure that they are not too low and thereby insure that this type of injury remains an infrequent accident. With the proper fitting of the head gear, face guards, and dental mouth pieces, facial injuries will become minimal athletic injury problems in football.

Contact Lenses: Special comment must be made about contact lenses. All too often, dirt will get under the lenses and the pupil may be scratched with a resulting scar and impaired vision. The coach should always have on hand a bottle of sterile distilled water with a dropper. A few drops in the affected eye will float the contact lens and wash the dirt away.

The Bloody Nose: A bloody nose is common in football. Remove the player from the game, clean out the blood clot, apply a long strip of a gelatin sponge to the affected nostrils. Then apply cold and pressure to the nostrils. Make sure that you have the gelatin sponge long enough, in order to remove it later. Remove it before the player resumes play. This treatment usually stops the bleeding in a few minutes and rarely will the nose bleed again unless it is re-injured.

Body Injuries

Fracture of the Clavicle: The athlete has landed on his shoulder or has been hit over his collar bone and complains of pain in that region. You will find a deformity, such as a moveable lump under the skin, tenderness, and inability to move the shoulder without severe pain. Place the arm in a sling and send him for immediate medical treatment. Make sure that all shoulder pads are properly fitted so that they are not too large. If they slip, the clavicles will be exposed to injury.

Sterno-Clavicular Joint: Sprains of this joint are common. There will be pain, tenderness, and abnormal freedom of motion of the inner section of the clavicle at its attachment to the sternum. Immediate medical evaluation is indicated.

Shoulder Separation: This common football injury may be very disabling, if not recognized early. The separation of the acromio-clavicular joint is usually caused by falling on the tip of the shoulder or from a blow to the top of the shoulder. There is a great deal of pain and swelling over the acromial process. If the separation is mild or incomplete, you may find only pain and inability to perform full shoulder movements. If severe or complete, you feel the end of the clavicle upwards under the skin and can press this down toward the acromion. This injury needs immediate medical treatment. The doctor must insist that the x-rays be taken upright with weights in both hands. If this has not been done, have the x-rays repeated as instructed; otherwise you may miss a shoulder separation.

Contusion of Shoulder: The top of the shoulder is a common site for this type of injury. The treatment is the usual contusion management but the danger is the possibility of missing a more severe injury. A shoulder contusion

should always be meticulously checked by the team physician.

Dislocations: The player will usually tell you what happened. There will be soreness to severe pain and marked limitation of motion. He will find it especially difficult to place his arm across his chest or abdomen. The most common dislocation is anterior-inferior. The arm is held away from his body. Just below the deltoid muscle, you will see a concave appearance instead of the firm muscular upper arm you would expect to see. Early reduction of the dislocation is mandatory and should be done only by a trained individual, preferably a physician. If swift medical care is not available, here is a safe procedure that the careful coach may try.

Place the athlete on a table face down with his arm hanging over the side of the table and attach about his wrist a ten pound weight. Do not place this weight in his hand as that will not allow muscle relaxation. Usually this traction will reduce the dislocation in about twenty minutes. When reduced, place his arm in a sling and obtain medical supervision and x-rays as soon as possible.

I have reached the conclusion that the first dislocation of a shoulder disqualifies the athlete from playing football for the season. I have not seen anything but re-dislocations as soon as he is allowed to resume play. If the dislocation is recurrent, he should likewise be disqualified. In spite of adequate non-surgical treatment and taping or using a shoulder-arm harness while playing, I have found that when the shoulder receives an anterior blow, it will be re-dislocated.

Upper Arm: Contusions of the upper arm are common football injuries. They follow a blow that produces a bruise or a hematoma. On examination you will find soreness or a severe rapid swelling. Rarely is there much limitation of movement. If the injury is mild, apply a pad and bandage for pressure, and give enzymes. After practice, use ice packs. If the injury is severe, immediately apply ice packs, pressure bandage, and give enzymes. After two days, hot packs may be applied. Protect this area with a sponge rubber pad for 7 to 10 days after it has healed to prevent re-injury. Myositis ossificans is fairly common, especially in the lateral brachialis muscle. If the hematoma is severe, the arm should be x-rayed at the time of injury and again after the football season. This injury predominately occurs in the right upper arm. (Most players are right handed and block with their arm instead of the shoulder.)

Contusion of the Elbow: This is caused, of course, by injury to an elbow. It usually produces pain, bruise, or a hematoma and swelling. It can be mild or severe. On examination you find tenderness. Feel and look for the swelling. Ice, enzymes, pressure bandage, and elbow pads are indicated in the mild cases. If severe, then immediately send the injured player to the team physician. A chip or more severe fracture may be present.

Elbow Sprain: The most common sprain of elbow is due to hyperextension and usually occurs to the athlete making the tackle. Swelling may be present. The player will tell you what happened and pain will always be present. Use immediate ice packs, enzymes, pressure bandage, and a sling. When the athlete returns to active play, he should have a daily restrictive taping applied to prevent any hyperextension of the elbow.

Contusion of the Forearm: This common injury is characterized by bruises and soreness. These contusions are usually found on the ulnar side of the forearm. A forearm pad to prevent further injury is indicated. Treatment consists of ice packs, enzymes, and if necessary, followed by hot packs.

Fractures of the Radius or Ulnar: Diagnosing these fractures may be difficult at times, as the athlete will complain of a great deal of pain. However, an examination reveals no deformity or swelling. If the pain on palpation is more severe than expected (especially over the radial side of the wrist or over the ulnar side) make sure that he is removed from play and is x-rayed. He may have a fracture at the growth line or a chip fracture

Wrist, Hands, and Fingers: Injuries here ac-

count for 60 per cent of all the types of football injuries. Fortunately, most of these are mild; and by daily padding and taping, the athlete does not have to miss a single practice. One inch tape is the adhesive of choice for these injuries.

The fingers are jammed, sprained, abrased, lacerated; the wrist sprained; the hand stepped upon; and at times these parts are contused, dislocated, or fractured.

Immediate treatment consists of ice packs, enzymes, and immediate protective taping or taping alone. Pain and swelling are almost always present.

Dislocation of the fingers is fairly common and usually involves the first or second joints. You see deformity of the finger. Dislocation of the thumb is not as frequent, but once in a while you do see a compound dislocation of the thumb. A dislocated thumb should be easy to recognize by its characteristic "step" like deformity. Dislocations should be immediately reduced by traction and then referred for x-ray to rule out a fracture. When the player returns to active play, a daily finger adhesive taping should be done for the remainder of the season.

Ribs: Any severe blow to the rib cage may produce a facture of one or more ribs. Localized pain, pain on breathing, and limitation of chest movements will be present. Routine adhesive strapping of the chest is the immediate treatment. This procedure should be followed up by medical management.

"Wind Knocked Out": This common injury follows a blow to the abdomen. The player is on the ground and he tells you what happened between his gasps for air. He will complain of weakness, dizzyness, and nausea. Reassure him that this will pass in a few minutes. Have him take slow deep breaths through his nose and exhale through his mouth. A few whiffs of ammonia will be of some help. After a short rest he may resume play.

"Stitch in the Side": This complaint is seen only in the early football conditioning program and usually follows an attempt to run the mile in six minutes. He stops running, bends over with a hand over the lower ribs on the affected side. Have him walk or rest for a while. This does not recur after the athlete is in good physical condition. Always instruct the football candidates about the importance of regular, adequate, and daily bowel elimination.

Lumbar Spinous Process Fractures: This type of injury is not uncommon and usually occurs to a player leading the interference and being hit from behind by the ball carrier's helmet. The chief complaint is a hot burning sensation over the site of the injury. Meticulous medical evaluation is immediately indicated.

Kidney Injuries: If the player has had a severe blow in the region of the kidneys, and is complaining of pain and holding his hand over the flank, see to it that he goes in and empties his bladder but have some responsible escort go with him. If gross bright blood is seen in the urine, medical evaluation is immediately indicated.

Always have a football player empty his bladder just before scrimmage or game time, and before the second half begins. If the athlete has a full bladder and receives a blow over the lower abdomen, he may sustain a bladder injury.

Abdomen: In football, these muscles are subjected to contusions but usually to no other soft tissue injury. The great danger is injury to one of the internal organs. When in doubt have him see the family physician.

Contusion of the Pelvis: This can be very painful and disabling. It is produced by a direct blow to the iliac crest. Daily protective sponge rubber pads and taping, following the contusion treatment, must be carried out until the injury has healed. Sometimes protective padding is required for the season.

Pelvic Strain: This injury is due to a severe blow along the crest of the ileum. Many peo-

ple refer to this injury as the "hip-pointer." You first discover severe tenderness along the iliac crest. This may only be a contusion, or it may mean a severe muscle tear. In contusion, when the athlete contracts his abdominal muscles or flexes to the opposite side, he does *not* complain of pain. If he complains of pain on these movements, then he may have done damage to the muscle attachments and this needs move thorough evaluation.

Sacro-Iliac and Lumbo-Sacral Strains: The player complains of severe ache to severe pain over these areas, especially following sprints or prolonged running. Proper daily low-back adhesive strapping, using two inch tape, until he is well is usually all that is required. It is important to x-ray these backs as many youths have congenital defects of the lower spine which have not been discovered until they begin to participate in contact sports.

Strain of Groin: This injury is seen frequently and is very disabling. The athlete is unable to perform any exercises and is in danger of getting out of condition. There is very severe pain in the groin with tenderness in this area on examination. It is usually located in the upper antero-medial aspect of the affected thigh. Begin the contusion management at once. In addition, the player must rest from two to seven days. When returning to play, slow progressive activity is in order. In spite of spica bandages and taping, rest and only rest is the most important aspect of treatment for groin injuries.

Contusion of the Thigh: Football injuries to the thigh are usually due to muscle injury. A contusion with hematoma formation is by far the most frequent. This injury might be avoided, as most of them are due to a small or too loosely fitting thigh pad. This is what athletes call "Charlie horse." The player complains of aches, soreness, or pain but usually not until after the scrimmage or game is over. The usual site of injury is in front or to the outside of the thigh. Begin the contusion treatment. Remember that any hematoma may become calcified. However, I have seen very few calcifications in the thigh.

When the youth returns to play, a protective foam rubber pad held in place with an elastic bandage, the thigh pad removed from the pants and placed over the bandage and taped in place affords the best protective procedure.

Contusions of the Knee are treated as any other contusion. On examination you will find swelling about the knee cap. This injury may take five to ten days to heal. This is sometimes described as "water on the knee." During this period of time, active quadriceps exercises are essential to keep the muscles in condition. Always have this injury checked by the family physician.

Knee Ligament Trauma: You first see the athlete coming out of the "pile-up" limping; or perhaps he has been unable to get up at all. Do not allow any player who runs back into the huddle limping to remain in the game or scrimmage until you have evaluated the injury. Early examination and removal from scrimmage may keep a sprain mild. If you allow him to be hit again, the injury may become severe. If he shows, on palpation and after rotating the leg outward and inward, very little pain, you should apply a firm elastic bandage. Then he may resume play.

If he has a great deal of pain over the inner or outer aspect of the knee and when rotation is performed complains of pain, send him immediately in for ice packs or cold whirlpool. Also begin enzyme therapy. After this, place two firm pads on both sides of the patella and enclose with a firm elastic bandage for pressure. Obtain medical evaluation as soon as possible.

If severe damage has taken place to his collateral or cruciate ligments or there is a torn cartilage, attended by much pain and disability, you know instantly he cannot resume play and needs definitive treatment.

When he returns to active play, it is important that he receive daily full knee strapping with or without a knee brace. I recommend both the brace and the strapping for the rest of the football season.

Lower Leg Trauma: Injuries to the lower leg, including the ankle, are the next most frequent injuries encountered on the field of play.

The lower leg is subject to abrasions, lacerations, and contusions daily. When they are severe, they will need immediate medical management. Fortunately, most will only require a protective pad followed by the usual treatment for any contusion.

"Shin Splints": We seldom encounter this troublesome condition in football. Slow, progressive, conditioning exercises (no running on hard surfaces and no sprints until properly conditioned) will prevent shin splints. In this lesion, the athlete complains of severe burning pain along his entire shin bone. Reassure him that it will pass. Apply ice packs and for a day or two have him walk and jog slowly about the field. Make sure that he knows how to use his ankle wraps. In football, the proper support from ankle wraps employing the heel lock will prevent shin splints.

Contusion and Strain of the Calf Muscles: A contusion due to a blow is very disabling and you find pain, tenderness, swelling, and muscle spasm over the calf muscle. Immediately begin the contusion management and slow activity until recovery.

Strain of the gastrocnemius muscle producing pain, swelling, and limping can be very severe and disabling. Start contusion treatment at once. Insist on two, three, or four days' rest to hasten recovery.

Injuries to the Ankle: A good ankle wrap is at least 90 inches long and is applied with the heel lock. This is the best daily preventive procedure against angle and knee injuries. On the high school level, it is a never ending job to check the wraps. Even then some become too loose when not properly anchored with tape.

Old ankle injuries should be taped daily. On game day, all ends and backs should have their ankles taped, while the linemen should have their ankle wraps reinforced with two adhesive strips (one and one-half inch tape) following the course of the ankle wrap.

Sprained Ankle: The athlete complains of pain and limps. You find swelling and usually "point tenderness" in front of, beneath, or behind the malleoli. There is pain on movement of the ankle. The immediate treatment is ice packs, enzymes, and pressure bandage. All ankle injuries should be carefully evaluated to eliminate the possibility of fracture.

If the athlete has no swelling—but when you squeeze just above the malleoli, he complains of pain—be careful! Many times, this is a sign of a fracture.

Achilles Tendon: There is danger of a rupture of the tendon. Have the athlete kneel on a bench with his back facing you. Grasp and squeeze the affected side calf muscles and if the foot moves toward you, the tendon is intact. If not, the tendon probably has been ruptured and medical treatment indicated.

Foot Injuries: In football, the most common cause of foot injury is having the foot stepped upon with resulting contusion, abrasion, and sometimes lacerations. At times a player will complain of a painful heel only on walking or on pressure. A soft heel pad daily will help, but if it persists he should see the team physician to rule out a fracture or a bone spur.

Blisters are very common, especially in the beginning of the season. Persuade the athlete to stop running the instant he feels a "hot spot." Apply Vasoline® to the part and reverse his inside sock. Thus blisters might be prevented. If a blister has formed, do not open it but apply firmly over it a strip of clear plastic tape until healed. If it is open, apply an ointment. On top, place clear tape over the blister. The danger here is infection. If you see red lines running up the foot and the presence of enlarged lymph nodes in the groin, a severe infection is present. Definitive medical treatment is indicated.

The clear plastic tape application allows the athlete to continue his conditioning while the blister is protected. I do not recommend changing his foot gear to sneakers as long as his football shoes are properly fitted.

Immediate Treatment and Management

A contusion is due to a direct blow to any part of the body with a resulting bruise or bleeding in the skin or deeper tissues with or without the formation of a hematoma. Cold applications and pressure bandages limit the bleeding, while enzymes promote absorption of the blood and tissue fluids.

Ice packs, cold water packs, or cold whirlpool baths to the part must be used as soon as possible after the injury. In high school, the application of ice should be for no less than the first 48 hours. If you recommend less, the athlete may only apply cold for one or two hours. When you insist on "48 hours," you may approach the seven hours of ice packs that I consider to be the bare minimum hours for ice pack application.

After the "48 hour" period has passed, hot packs are indicated to stimulate circulation. I believe in contrast packs. Use twenty minutes of hot packs followed by crushed ice cubes for five minutes directly over the point of maximum injury. This should be done at least four times daily and more frequently if the athlete has the time. If you "over-congest" the recent injury, secondary bleeding may occur; and that is why I recommend "cooling down" the point of maximum injury for five minutes. After two or three days of the contrast packs, hot packs are recommended until healing has occurred.

Abrasions and lacerations are cleansed and covered with protective sterile dressings. If severe, definitive medical treatment (sometimes including sutures) may be indicated. Always check with the athlete as to when he has had his last tetanus booster. All football players should have a booster before the season begins.

Strains and sprains if accompanied by a blow, bruise, swelling or hematoma, require the contusion management. If there is no bleeding or swelling, hot packs should be used.

What I have just said may be a dangerous statement to make. One of the most disabling situations will develop if heat is applied to the wrong type of injury. If heat is applied to a contusion, bleeding tissue, a hematoma, or a sprained ankle, these injuries will "blow up" tremendously due to continued bleeding. The athlete will be disabled for weeks for an injury that should only have caused two or three days of disability.

For dislocation, treatment of choice is immediate reduction of the joint. Reduction of dislocated fingers is accomplished by traction and is easily performed. Remember that this injury should be x-rayed to rule out an accompanying fracture.

Dislocations of the shoulder or elbow are not to be handled by anyone who is not properly trained. If no physician is available, take the player to the nearest hospital as soon as possible.

97 Madison Place

Don't dismiss the innocent looking paronychium, whitlow, or "fungous infestation" around a nail bed. It might be malignant!

Melanotic Whitlow

Report of a Case

Martin H. Wortzel, M.D./Millburn

A malignant melanoma may appear on any part of the skin at any time. Insidious in onset, it is difficult to detect it clinically in its early stages. A most disarming type of malignant melanoma is that seen around the nail bed and known as a melanotic whitlow. This case report should underline the necessity of suspecting malignancy even in a harmless-looking paronychium or "fungous infection" of the nail.

Malignant melanoma or nevocarcinoma arises as a neoplasia of melanoblasts or melanocytes at the epidermodermal junction of the cutaneous surface[1] or the junction of the epithelium and the tunica propria of the mucocutaneous junctions or mucosae.[2] Becker[3] states that "most of these tumors originate in lentigo malignae and not in pigmented nevi."

Clinical signs of transition to malignant melanoma are: increase in size or depth of color; formation of crusts; bleeding or ulceration; adenopathy or the formation of firm nodules within a mole or as satellites about it. At its onset, the tumor may be only pinhead to pea size. It soon grows much larger becoming papillary, fungoid, or ulcerated. Pigmentation is usually not uniform throughout the tumor but may be scattered or appear as irregular, greyish-brown, bluish-black, or black spots. Sepia or coal-black spots appear "sprayed about the lesion."[3] A malignant melanoma in which little or no pigment forms has been variously designated as a leucosarcoma, amelanosarcoma, amelanoma, nonmelanotic melanoepithelioma, amelanotic melanoma, and nevocytoblastoma or malignant nevocytoma.

Fortunately, the disease is rare, occuring in about 4 percent of all malignancies of the skin and lips.[4] About three-fourths of the cases develop in persons between the ages of 30 and 70 (average age is 47). It is extremely rare among children and in Negroes. Although no area of the skin is exempt, the most common sites of malignant melanomata are reported to be the head, neck, trunk, and genitals. The least frequent sites are the limbs, especially the hands.[5]

Melanotic whitlow, also called subungual melanoma (melanic panaris, onychial malanoma), develops in the nail bed or lateral nail fold. It occurs in about 3 per cent of all malignant melanomata[6] and begins as a small ulcerative process, beneath the nail or at its margin, and gradually invades the nail bed lifting the nail as it progresses. As far back as 1886, Hutchinson[7] described melanotic whitlow as a "black, fungating, well-demarcated ulcer that may exhibit a purplish area of granulations flecked with black." The dark margin or halo of black around the edge of the ulcer is pathognomonic of the disease.

Early diagnosis of melanotic whitlow is desperately important and just as difficult. Becker[3] complains that most physicians close their minds to the presence of malignant melanomata and that diagnosis is usually made during the advanced stages of malignancy. The nonpigmented variety or malignant amelanotic melanoma is almost never diagnosed clinically.

Diagnostic Criteria

At its onset, a melanotic whitlow may masquerade as a simple split nail, an ingrowing nail, or a fine blue line resembling a pencil mark down the center of the nail, or as a lightly pigmented, small, brown spot in the lateral nail fold, eponychium, or matrix. The adjacent part of the nail may be slightly eroded, uplifted, furrowed or scaly, in which case a fungous infection is generally suspected. In time, the lesion becomes nodular or multinodular, and metastases develop in the axillary or epitrochlear lymph nodes. Local ulceration is usually a late development.

The following case report illustrates one of the devious and subtle forms in which melanotic whitlow masquerades:

A 58-year-old housewife who worked part-time in her husband's luncheonette and whose hands were constantly in contact with water and detergents had, on three occasions during the past four years, developed acute paronychiae. These responded to local medications each time.

Concurrently, she developed diabetes mellitus which was well controlled by diet and one oral hypoglycemic tablet daily. Six months before her first visit to my office, she had noticed a paronychium on the lateral surface of the right thumb which failed to respond to local applications of boric acid soaks and an antibiotic cream obtained from her pharmacist. The swelling continued to spread medially and gradually involved the entire nail base. Pus formation was never observed. The nail became distorted and grew with horizontal furrows. A dermatologist treated the thumb with x-ray and griseofulvin, despite the fact that two cultures had been negative for Tinea and Monilia. In addition to radiation and internal medical treatment, she continued to apply various local medications such as Amphotericin-B, Vioform, nystatin, and neomycin.

Initial examination at the time of her first visit to my office revealed a chronic paronychium of the right thumb. The base of the nail and lateral nail fold were distorted, and the area surrounding the paronychium was swollen, erythematous, and exfoliating. There was no evidence of pigmentation. The lateral third of the nail was ridged, desquamating, and easily picked away revealing subungual hyperkeratosis characteristic of chronic fungous infection.

®Biopsy was taken through the paronychial tissue and nail bed. Pathologic examination by Dr. A. B. Hyman revealed "a measure of junction activity near one edge of the biopsy specimen. The epidermis was invaded by individual cells of bizarre nevus types. The cutis was almost entirely occupied by closely set lobules of cells of nevus origin showing considerable nuclear variations, extensive vacuolation, and scattered minimal pigment. There was considerable inflammation in the stroma. The histopathology is consistent with that for malignant melanoma."

The patient was treated by conservative surgery, and the thumb disarticulated at the carpo-metacarpal joint including the trapezoid and trapezius bones. Regional nodes and axillary glands were not dissected.

The patient is alive and well 24 months after surgery.

Were it not for the past history, chronic fungal infection might well have been the diagnosis in this case. This demonstrates the difficulty in early detection of melanotic whitlow and emphasizes the importance of suspecting malignancy in a history of: (a) any form of pigmentation in, under, or about a single nail, especially if the pigmentation is increasing; (b) chronic onychia, paronychia, or granular excrescence involving a single nail and which is painless, refuses to heal, or increases; (c) splitting, cracking, or displacement of a single nail whether or not explainable by concurrent disease; and (4) any of these changes developing or persisting for an unusual length of time following trauma.

Melanotic whitlow must also be differentiated from those other conditions that may closely resemble it such as: *Subungual abscess,* which gives evidence of acute inflammation but readily responds to drainage; *Subungual granuloma,* which subsides rapidly with dermatologic treatment and is soft, vascular, rapidly growing, and has a "punched out" demarcation line; *Onychomycosis nigricans,* a pigment-forming fungous infection closely resembling malignant melanoma but showing typical fungi in smears or culture; *Subungual hematoma* coupled with a traumatic origin, which tends to disappear rather than progress; *Subungual or sulcus chancre,* which shows Spirochaeta pallida when a smear of its secretion is examined by dark field microscopy and in the presence of which a positive Wasserman will eventually be found; *Subungual exostosis* or *osteochondroma,* which show a bony excrescence on x-ray examination; *Fibroma and epithelioma,* a subungual lesion of the *angiosarcoma of Kaposi,* which is but one manifestation of a multicentric disease with many scattered lesions; and *Subungual glomus tumor,* which is characterized by paroxysms of severe radiating pain, whereas malignant melanoma is generally not a painful disease. To this list, Pack and Adair[8]

would add gangrene of the toe, and Becker,[3] subungual larva, syphilitic dactylitis, and myeloma.

Prognosis

Prognosis in malignant melanoma is usually poor, but melanotic whitlow offers a more favorable prognosis than other nevocarcinomata, if diagnosed early enough. This is because of its location, slow growth, and late dissemination. Local recurrences have been reported to be common. Metastases occur along the lymphatics and in the regional lymph nodes. Generalized dissemination of the tumor through the blood stream is late. Pack[9] asserts that malignant melanoma spreads to the brain more commonly than any other tumor does.

Summary

A detailed description of melanotic whitlow and a report of a rather atypical case have been presented. It is important for the practitioner to suspect melanotic whitlow in the presence of any chronic infection in, around, or under the nail that does not respond to conservative therapy. Biopsy is an essential aid in the diagnosis.

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Dr. H. J. Montoye, Pem Building, University of Michigan, Ann Arbor, Michigan, 48104, is the Secretary of the College of Sports Medicine.

With acute idiopathic pericarditis, one expects electrocardiographic changes. Here is one without this finding: a rarity.

Acute Idiopathic Pericarditis*

Report of a case without electrocardiographic changes

Martin G. Blechman, M.D.
Charlotte Sokol, M.D. / **Hackensack**

Cases of acute idiopathic pericarditis are well known with the classical features of pain, dyspnea, fever, chills, general malaise, "to and fro" friction rub, and the initial electrocardiographic changes of upward displacement of the RST junction and the ST segment. Review of the American literature reveals only twenty-five cases that presented without significant electrocardiographic changes. It is certainly conceivable that the frequency of acute idiopathic pericarditis without electrocardiographic changes is much higher than it appears. The following case report stresses the fact that all the clinical features may be present while the electrocardiogram may be normal.

A forty-year-old housewife who always enjoyed good health was admitted to the Hackensack Hospital on December 18, 1963. One and a half weeks earlier, she had developed symptoms of an upper respiratory infection which failed to clear with self-medication. On December 16, she went to her local physician with precordial pain aggravated by respiration, a non-productive cough, and a low grade fever. Physical examination then was essentially negative, and she was treated with salicylates and tetracycline. Symptoms persisted, and on the day of admission, her blood pressure was 130/80, pulse was 100, and temperature was 101. She had dullness and bronchoegophony in the left lower paravertebral area. The heart was enlarged, the left cardiac border extending to the anterior axillary line; there was a loud "to and fro" gritty-to-hard pericardial friction rub best heard along the left sternal border. The rhythm was regular and no murmurs were heard. There was no evidence of congestive heart failure. There was no significant adenopathy, and the peripheral pulses were normal. The remainder of the physical examination was normal.

Chest x-ray on admission (Figure 1) showed a heart moderately enlarged with predominence of the left ventricle; there was some evidence of fluid in the left pleural cavity. The retrocardiac space was obliterated. The lung fields were clear. The initial electrocardiogram showed a one millimeter inversion of T III, flattening of T AVF, and a normal P-R interval. There was a moderate anemia with a hemoglobin of 10.2 Grams, hematocrit 32 percent and moderate poikilocytosis on smear. White blood count was 7,300 with a normal differential. Sedimentation rate was 111 millimeters per hour (Westergreen); lactic acid dehydrogenase 300 units; blood urea nitrogen 13 milligrams percent; serum glutamic oxalacetic transaminase 40 units; lupus erythematosus preparations were negative; venereal disease research laboratory, negative; bilirubin 0.8 milligrams percent with an indirect bilirubin of 0.6 milligrams percent; heterophile titers negative; cold agglutinins negative; stools for occult blood negative; throat and blood cultures negative; Tine test for tuberculosis negative; stool and serum studies for viruses negative. These studies were done by the New Jersey State Department of Health by inoculation into Monkey kidney and HeLa Cells. The studies indicated no significant reaction to the Coxsackie B1, B2, B3, B4, and B5 antigens.

An electrocardiogram taken on December 20, 1963, revealed only flattening of T III, with a normal T AVF. All subsequent tracings were normal.

Three days after admission, there was a temperature spike to 104 and the patient appeared toxic. Physical signs remained unchanged, except for an increase in heart rate. A chest x-ray taken on that day (Figure 1, December 21, 1963) demonstrated further increase in the transverse diameter of the heart. Because of this marked temperature rise, evidence of increasing cardiac size and the patient's generally toxic appearance, steroid therapy was instituted. She initially received prednisone, 20 milligrams, three times a day, with a rapid fall in temperature, a marked clinical improvement and progressive diminution in heart size. On the third day of steroid therapy, her temperature was normal and she remained afebrile for the rest of hospital stay. The chest pain, the friction rub, and the area of dullness in the left posterior thorax cleared by the end of the first week of therapy. A repeat chest film (Figure 2, December 30, 1963) showed a marked decrease in the transverse cardiac diameter with clearing

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FIGURE 1
Chest x-ray 12/21/63.



FIGURE 2
Chest x-ray 12/30/63.

of the retrocardiac space. Only a small amount of residual fluid in the left costophrenic sucus remained. Serial chest films showed progressive changes toward improvement. A repeat hemoglobin was 12.6 grams percent; reticulocyte count was 2.8 percent. On January 1, 1964, the patient was discharged from the hospital on prednisone, five milligrams a day and salicylates, 600 milligrams, four times a day. The steroids were discontinued on February 6, 1964. She remained on salicylates until March 1, 1964.

Three months following her discharge, the cardiac silhouette remained normal, as has the electrocardiogram. There has been no evidence of any clinical relapse one year after her illness.

Porte[1] in 1929 was one of the first to describe the electrocardiographic changes in pericarditis. He published three case records of "the occurrence of the coronary T-wave" in patients of rheumatic etiology. In 1958, McCall[2] studied 18 patients, 4 of whom failed to show early changes, and only in the second week was there flattening of the T-waves in Leads I and II. Sodeman[3] in the same year found 38 cases; 8 percent had normal electrocardiographic changes and 26 percent showed nonspecific changes. McCuiston[4] in 1959 reviewed all the available data on patients with idiopathic pericarditis. He found 325 cases; six percent had normal electrocardiograms and 30 percent had nonspecific ST-T changes. He reported on an additional 23 of his own cases, where 8 percent had no electrocardiographic changes and 17 percent had nonspecific changes. In 1960, Soffer[5] reviewed 31 cases; 3 percent had no electrocardiographic abnormalities. Kavelman[6] in 1961 reported ten cases that showed only T-wave instability.

The appearance of ST-T changes in acute idiopathic pericarditis depends on many features: the electrical axis, the position of the heart, and the extent of subepicardial injury.[2,6-8] If there is no involvement of this region, there are no changes and pathology is limited to the pericardium. It is not unusual that graphic changes lag behind clinical findings.[6] The nonspecific changes may only consist of lowering or inversion of the T-wave. The implication of these changes is that the acute inflammatory process beings to subside and permits repolarization to take place slowly.[9] In the case presented, it is difficult to accept the absence of myocardial involvement in a patient who is acutely toxic four days after admission, showing increasing pericardial effusion, a temperature of 104, and all the clinical features of acute idiopathic pericarditis.

Summary

A forty-year-old white female is presented with all the clinical evidence of acute idiopathic pericarditis. At no time did the electrocardiogram show any significant changes. A review of the literature accounted for 25 cases. It is conceivable that the frequency of acute idiopathic pericarditis without electrocardiographic changes is much higher than reported. The pathophysiology is discussed.

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280 Prospect Avenue

The Mittmann-Poche Controversy

In 1964, an article* appearing in *Zeitschrift für Krebsforschung* by Poche, Mittmann and Kneller was given widespread publicity in the popular press. The study purported to show that there was no association between cigarette smoking and incidence of bronchial carcinoma as observed in 1,229 cases of lung cancer.

Controversy was not slow to follow.

Among the principal questioners of the article was Dr. Siegfried Koller, Chief of the Institute for Medical Statistics and Documentation at the University of Mainz, and a member of the Zeitschrift's own editorial board. In a subsequent issue of the journal, Koller† gave a detailed refutation of the Poche article: a refutation which was also an attack on the design of the original study.

Among the chief points which Koller† raised were: That selection of cases was faulty; data actually requested on smoking habits were fragmentary and ambiguous; there was no control group; histologic grading may have been far from uniform throughout the series: statistical parameters were dubious; the correlation of data from international sources compared essentially unlike groups and was hence worthless. Koller† concluded "That the material prepared by the authors has no relevance to the problem of the influence of smoking on bronchial carcinoma. Considering the important errors in source material, it is without significance that the authors could not demonstrate this relationship statistically."

Other comment by Dr. Siegfried Heyden of Zurich (Selecta, February 15, 1965) states that the Report by Poche and his colleagues* is not a "representative investigation." He believes the crux of the report lies in the questionnaires and criticizes the material gathered from military service and war imprisonment. Dr. Heyden said he does not agree with Professor Poche and his colleagues. And Dr. Ferdinand Schmidt of Potsdam said he regrets that this article* was published The report has done a disservice to German science.

In view of the extensive publicity given the Poche article*, it is vital that physicians be made aware that serious doubts have been cast on its validity by recognized authorities.

* Poche, R., Mittmann, O., and Kneller, O.: Statistische Untersuchungen über das Bronchialcarcinoma in Nordrhein-Westfalen. Zeitschr. Krebsforsch. 66:87 (1964)

† Koller, S.: Bemerkungen zu der Arbeit von R. Poche, O. Mittmann und O. Kneller: "Statistische Untersuchungen über das Bronchialcarcinoma in Nordrhein-Westfalen:" Zeitschr. Krebsforsch. 66:187 (1964)

Primary carcinoma of the ureter is rare enough to justify a case report.

Painless Hematuria in Ureteral Carcinoma

Donald Cowlbeck, M.D.
Paul Parker, M.D.
Thomas K. Rathmell, M.D. / **Trenton**

A 58-year old man was admitted to The Mercer Hospital complaining of bloody urine. Two days prior to admission, he had noticed red urine without clots or pain. The urine became clear for two days. Then he again noted red coloration of the urine. He denied any history of previous kidney disease. The family history was noncontributory. He had had a pilonidal cyst excised in 1959 and a herniorrhaphy in 1954.

He was a well-developed man in good physical condition. Nose and throat were normal. The thyroid was not palpable. Cardiopulmonary examination was within normal limits. Blood pressure was 150/90. There were no murmurs or friction rubs. Abdominal examination showed no palpable masses or acute tenderness.

Urinalyses showed a specific gravity of 1.017 and 1.020. Red blood cells were present to the number of 20 to 25 per high-power field. Casts were absent. Blood count showed normal hemoglobin and red cell levels with a total white blood cell count of 15,300 cells per cu. mm., of which 83 per cent were polymorphonuclears, 15 per cent lymphocytes, and 2 per cent monocytes. The biochemical studies showed a fasting blood sugar of 117 mgs. per 100 milliliters. Blood urea nitrogen was 20 mgs. per cent. Urine cultures were negative at the end of 48 hours. Chest x-ray was normal. Electrocardiogram showed a left axis deviation.

Cystoscopic examination revealed only bladder trabeculation, and left renal disease was considered. Intravenous pyelogram showed moderate dilatation of the left kidney pelvis and calyceal system. A concavity was noted at the inferior aspect of the bladder, evidently due to extrinsic pressure from an enlarged prostate gland. However, retrograde pyelography demonstrated marked dilatation of the left renal pelvis and calyceal system. In addition, an irregularity of the proximal portion of the left ureter as well as the juncture of the middle and distal third was noted. The right urinary tract was essentially negative.

Following these studies, he was subjected to a left nephroureterectomy under spinal anesthesia. The left kidney was found to be normal in size with dilated calyces. A segment of the ureter attached to the kidney presented as intraluminal papillomatous structure which obliterated the ureteral lumen.

Preoperative medication consisted of 50 mgs. of Demerol,® 1500 cc. of 5 per cent dextrose with 180 mgs. of Furadantin® and 2 cc. ampule of Fulbesyn.® Postoperatively, morphine sulfate, grains 1/6, was given for relief of pain. Three days following surgery, the urea rose to 27 mgs. per cent. However, on the day of discharge, it had returned to 19.

Study of the left kidney showed it to measure 12 by 7 by 6 centimeters. It appeared to be of normal size, brownish-red in color, and firm in consistency. The capsule stripped without difficulty. The cortical surface was smooth and glistening. On section, the cortex and medulla were well outlined. They had a combined

thickness of 12 millimeters. The pelvis was enlarged to twice its normal size. The calyces showed dilatation; however, the mucosal lining of the pelvis appeared grossly uninvolved.

A segment of the ureter measuring 16 centimeters in length was attached to the kidney. It had an average perimeter of 12 millimeters. Three centimeters from the distal end of the surgical excision, the ureteral lumen was obliterated by an intraluminal papillomatous



structure measuring 3 centimeters in its largest dimension. It was implanted with a pedunculated pedicle which measured 8 millimeters at the base. Focal areas of hemorrhage were noted over the papillomatous structure. An additional specimen from the distal portion of the ureter measuring 8 centimeters in length and 5 millimeters in diameter was also studied. This showed complete obliteration of its lumen.

Histological study revealed a papillary type of transitional cell carcinoma of the ureter surrounded by its muscular wall and with some submucosal edema. Exfoliated cells within the lumen of the ureter showed hyperchromatic nuclei and were clumped. Sections of the ureteral polyp showed a papillary arrangement of the epithelial cells. The stalk of the polyp showed dilated vascular channels and necrosis. The individual cells showed vesicular nuclei and prominent nucleoli. The renal cortex presented 10 glomeruli per low-power field. They were all functional. Lymphocytic foci were seen in areas throughout the interstitial tissue. The distal convoluted tubules showed evidence of epithelial necrosis.

Pathologic diagnosis was left kidney with mild hydronephrosis with a left ureteral polyp showing well differentiated carcinoma.

Primary carcinoma of the ureter is rare. It is found most frequently during the fifth and sixth decades of life. Metastatic seeding from other primary lesions sometimes involves the ureter more frequently than primary growths. Metastasis may occur in the regional lymph nodes, liver, lungs, bone marrow, or any other organ. Hematuria is an almost invariable clinical finding from the onset of the neoplastic growth. The tumors in this location naturally produce obstructive phenomena. Death from dissemination of the tumor is a rare phenomenon; nevertheless, we have previously examined one such case in this hospital.

The patient was discharged 18 days after initial hospitalization.

446 Bellevue Avenue (Dr. Rathmell)

Tolbutamide and chlorpropamide, like most effective drugs, have a capacity for mischief if given too glibly and not properly supervised.

Severe Hypoglycemia Induced by Chlorpropamide in a Non-Diabetic

Philip J. Del Vecchio, Jr., M.D.*
Bloomfield

Mild hypoglycemia secondary to administration of sulfonylureas in therapeutic doses is not an uncommon problem. It usually takes the form of transient reactions which may or may not require adjustment of the dosage.[1,2,3,4] However, in recent years there have been several case reports of profound and prolonged hypoglycemia due to sulfonylurea therapy, both in diabetics and non-diabetics.

This complication (once thought to be rare) is most frequently reported secondary to tolbutamide,[1] but there are now three cases in the American literature in non-diabetics[5,6,7] as well as several in diabetics,[8 to 12] due to chlorpropamide. Of the non-diabetics, two were volunteer test subjects who received much higher doses of chlorpropamide than advised for clinical use and one took an undetermined dose, presumably very high.

The following case shows that chlorpropamide, like tolbutamide, is capable of producing serious hypoglycemia when given in the higher limits of the usual therapeutic range to a non-diabetic patient.

A 23 year-old woman was admitted to the Emergency Room at Mountainside Hospital on October 31, 1964, in a semi-conscious state, with a presumptive diagnosis of diabetic coma. A year prior to admission, she had been told that she had glycosuria on a routine preemployment examination. Her family physician then obtained a normal blood sugar level and reassured her. Two weeks prior to admission, glycosuria was again noted during a job application, and she was referred to another physician. Despite the finding of a normal blood sugar, she was advised to "stay away from sweets" and was given tablets to take (later found to be chlorpropamide, 250 milligrams), once daily for three days, then increasing to two tablets daily.

She took the medication for ten days and returned to see her physician two days prior to admission. Since glycosuria was still present, the dosage was increased to three tablets daily. She took three tablets the following day and then only a single tablet the morning of admission. While at work on the day of admission, she began to show very inappropriate and bizarre behavior and at first was thought to be intoxicated. A physician found 4-plus glycosuria and advised hospitalization.

On admission she was found to be semi-conscious, responding to verbal and painful stimuli. Blood pressure was 130/90, pulse 84 and regular, respirations normal, and the skin warm. Physical examination was entirely within normal limits. There were no positive localizing neurologic findings.

An emergency blood sugar drawn at 5:45 p.m. was 24 milligrams per cent (true glucose) and at 6:15 the patient was given 50 cubic centimeters of 50 per cent dextrose intravenously, with immediate and dramatic conversion of her depressed cerebral function to a normal state. She then received 400 cubic centimeters of sweetened orange juice and a slow infusion of 5 per cent dextrose was started. The admitting resident, in the belief that the patient represented a case of hypoglycemia in early diabetes, ordered fractional urine coverage with regular insulin, to start in the morning. At 3 a.m. the following morning she was given 210 cubic centimeters of orange juice because of a feeling of "weakness." At 5 a.m. the urine showed 4-plus glycosuria, and she received 20 units of crystalline zinc insulin. At 7:15 a.m. she complained of epigastric pain, relieved by breakfast about an hour later. The 10 a.m. urine was 4-plus and she received 15 units of insulin. The 8 a.m. blood sugar, reported at noon, was 14 milligrams per cent.

At luncheon, the patient was alert and hungry. She ate two full meals and took three glasses of sweetened orange juice in the next three hours. There were no positive physical or mental findings. The low morning blood sugar was attributed to the insulin she had received, which had then been discontinued. At 4:30

* Resident in Internal Medicine, Mountainside Hospital, Montclair.

p.m. she suddenly became very drowsy and difficult to arouse. Blood was drawn and an infusion of 10 per cent dextrose was started, again with complete reversal of her mental clouding in a few minutes. The blood sugar was reported as 8 milligrams per cent.

At 8 p.m., after the patient had received almost a liter of the infusion with 100 milligrams of hydrocortisone added and after she had eaten a full supper, her blood sugar was only 58. A similar infusion was given through the night, and at 8 a.m. on November 2 the blood sugar was 159. Thereafter she was maintained on a high carbohydrate diet throughout her hospital stay, and repeated fasting and random blood glucose tests were all normal. After three days of preparation, an oral glucose tolerance test on November 5 showed:

	Blood sugar	Urine sugar
Fasting	94 mg.%	0.77%
30 min.	132	2.01
60 min.	110	0.90
90 min.	94	0.84
120 min.	104	0.20
150 min.	82	0.40

An intravenous tolbutamide tolerance test was normal. Further laboratory studies, including complete blood count, microscopic urinalysis, serum electrolytes, urea nitrogen, serum creatinine, albumin-globulin ratio, cholesterol, alkaline phosphatase, thymol turbidity, total proteins, serum and 24-hour urinary phosphorus, serum and urine acetones, Kollmer Wasserman and VDRL were all negative or normal. Urine specimens taken every four hours all showed 1-plus to 4-plus glycosuria, with the exception of a single negative nocturnal specimen. In each instance, the urine sugar was verified to be glucose.

Information obtained from the patient revealed that at least one of her sisters and a maternal aunt have "sugar in their urine" with normal blood sugars. Plans are underway to attempt to document a family pattern of renal glycosuria.

The incidence of significant hypoglycemia (usually defined as a true blood sugar less than 50) due to chlorpropamide in the therapy of diabetes has been reported in various series to range from zero[13] to four per cent.[9] There have been many reports citing mild hypoglycemia on a clinical basis, frequently without defining the signs and symptoms noted, and even more often without documentation of blood sugars. The difficulty in making a strictly clinical diagnosis is that too frequently noted side effects of chlorpropamide (a feeling of generalized weakness and epigastric distress sometimes described as hunger pains) are true effects of the drug and not necessarily related to blood sugar levels.[14] Most often, true hypoglycemic reactions have been dose-related, occurring in the higher dosage ranges of 500 to 750 milligrams daily, although hypoglycemia has been reported with dosage as low as 100 milligrams daily in a patient with chronic renal disease.[4] The incidence of reactions was much higher during the first few years the drug was in use, when the recommended dosage was higher than at present. Most patients who have had moderate reactions have been able to tolerate a reduced dosage while still maintaining good diabetic control.

Previous reports of chlorpropamide-induced hypoglycemia in non-diabetics include that of Bloch and Lenhardt,[7] who describe a 22 year-old who received 3.5 grams over four days, became hypoglycemic on the fourth day (blood sugar 43), and remained hypoglycemic for three days despite continuous therapy. Sackner and Balian[6] report a 45 year-old volunteer who was given 2 grams on each of two days, became hypoglycemic on the third day, and still had high serum chlorpropamide levels on the seventh day, eventually suffering permanent brain damage. The patient reported by Duncan, *et al.*,[5] had several confirmed hypoglycemic attacks due to occult ingestion of unknown amounts of chlorpropamide. All these patients received much more than the usual therapeutic dosage.

It is to be expected that many more cases of hypoglycemia will be reported as further clinical experience accumulates. Probable mechanisms for the hypoglycemia include the potency of chlorpropamide, which appears to be at least twice that of tolbutamide on an acute dosage basis, and the fact that it is excreted essentially unmetabolized.[14] The most important factor, however, seems to be the long serum half-life of 30 to 36 hours for chlorpropamide, which apparently accounts for the prolonged states of hypoglycemia which have been observed, some as long as 72 hours.[15]

The possibility of leucine sensitivity manifested as hypoglycemia has not been investigated in the present patient. Fajans, *et al.*,[16] report that after pre-treatment of normal patients with sulfonylureas, oral or intravenous leucine produced a consistent marked decrease in blood sugar similar to that seen in patients with idiopathic hypoglycemia or islet cell adenomas who are given leucine.

They postulate that the mechanism involves augmented release of endogenous insulin, although others feel that leucine diminishes the normal defense responses to hypoglycemia, specifically by decreasing hepatic glucose output.[17] The latter, however, is also an action of endogenous insulin, and, therefore, the two viewpoints may coincide. The significance of these findings in clinical patients receiving sulfonylureas is not known.

This patient's symptoms of hypoglycemia fit into the pattern of diminished cerebral function as described by Sussman, *et al.*[18] Although there were some indications of parasympathetic response during her in-hospital hypoglycemic episodes, at no time did she demonstrate the classical sympathetic response, presumably because of a gradual, rather than abrupt, lowering of the blood sugar.

It must be noted that the blood sugar of 8 milligrams per cent at 5 p.m. on November 1 may have been partly influenced by residual effects of the insulin given at 10 a.m., despite the very high caloric intake during the day. However, the persistently low value of 58 milligrams per cent at 8 p.m., despite the administration of 100 Grams of glucose and 100 milligrams of hydrocortisone intravenously, strongly suggests persistent chlorpropamide effect, 36 hours after the last dose of the drug.

Summary

A case of profound and prolonged hypoglycemia secondary to chlorpropamide therapy in the therapeutic dosage range to a patient who was normal except for renal glycosuria is reported. The potentially catastrophic possibilities of incorrect diagnosis and misuse of this potent drug are evident. Previous case reports are reviewed, as are some possible mechanisms for the hypoglycemia.

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71 Barbara Street

New Health Brochure Now For Sale

The brochure, *Your Health is Your Business,* is available at 25¢ each (lower prices for ten or more copies) from Public Affairs Pamphlets, 381 Park Avenue South, New York City 10016. Written by Harry J. Johnson, M.D., it reviews heart disease, alcoholism, cancer, annual physical examinations, and similar health topics, with a good doctor-focused orientation for the lay reader.

Liberty is lost less often by the machinations of evil men than by the apathy of good men.

When Good Men Do Nothing*

Elbert H. Pogue, M.D./Elizabeth

In antiquity, the practices of the healing art and of religion were inextricably intertwined. Indeed, the priest and physician were most often one and the same. He was not loved, but he was respected and at times greatly feared. The ridiculous sketches of physicians in Moliere's comedies and the savage etchings of Goya in which physicians appear with donkey heads cannot be dismissed as mere caricatures. They also portray the inadequacies and pomposities of medicine during their times.

A century ago, in this country, the physician was often the best educated man in his community. In a small community this meant that the doctor, the lawyer, the minister, and the school teacher were looked up to as leaders. Even in the larger towns and cities, the physician was a man of stature by reason of his educational background. Today he is still a man of stature, but too often his field of influence is limited to his own profession. This is due in part to the fact that people today are better educated in the formal sense and have better communications and transportation, but it is due in part also to the fact that too many of us show little interest in the affairs of our communities.

Another factor that has changed the concept that the public once held of the average physician is the strong force of social change that is sweeping the entire world, including this country. The federal government, labor organizations, and other self-appointed guardians of the public's health have taken upon themselves the determination of what should be done to provide health and medical care for the average citizen. All of these organizations presume to build on a foundation and medical tradition that they in no way created, and to which they have made no significant contribution. Here I refer to the private practice of medicine. I suppose some of this feeling is due to the fact that no one wants to be sick and therefore resents having to seek medical advice and care; yet, it is my feeling that more sinister forces are at work.

In some instances the advocates of plans to control medical practice, set fees, and provide for the aged are simply using a handy political foil. Others have blinded themselves with the contention that medical care is so expensive that the average citizen cannot afford medical and hospital care and therefore the government must provide it. The ultimate conclusion in such logic is that, likewise, housing and food are too expensive and so the government should provide them. Thus, as a people we gradually are embracing a degree of socialism that will mean the end of democracy as we know and cherish it.

I would point out to those who reason thus that we have a problem with the elderly because the elderly are with us, and the elderly are with us because many now survive who in other years would have died of infectious diseases or other ailments that have been but recently conquered. This point seems to have been missed by those who are medicine's most vocal critics. These critics would be happy to

* Address of the retiring President of the Union County Medical Society, March 10, 1965.

set up plans that will control your life and mine, but here again it should be pointed out that these planners would make use of the talents and time of a professional group already in existence and which has achieved a degree of excellence through study and perseverance based on the work of medical pioneers of earlier days.

Perhaps it is time that we physicians took a hard look at ourselves. We constitute a very special minority group that brings little to a community in the way of problems but much in the way of assets. None of us is too young to make a constructive contribution, since one grows older in the process of becoming a doctor. Our crime rate is low as is the number of us who became public charges. Our charitable works are taken so much for granted that there are those who believe that we must regularly be paid for them because no one would be foolish enough to do all of that work without compensation.

Doctors and their families contribute in many ways to their communities. A good doctor is in demand and so is busy; and being busy, he becomes prosperous, and this is the rub. His prosperity is resented, although I am sure that most of his detractors would not trade places with him if they had to accept his working hours along with the fruits of his labor.

Professional freedom has always been one of the more attractive reasons for an individual's choosing medicine as a career. In the recent past, events in Britain, Belgium, Canada, and Italy have demonstrated what happens when doctors are shorn of their professional freedom, stripped of their pride, and treated as ordinary workers. They simply react like ordinary workers and use the slow-down, the boycott, and even the strike. Thus the people, the profession, and the nation suffer, and wounds are left that take decades to heal.

No chain is stronger than its weakest link. Most of us are cognizant of our responsibilities; most of us live up to our moral, ethical, and legal obligations. But there are a few who take the best our profession offers in status and monetary reward, and who then shortchange their patients and their community. It is this small group that makes it so hard for us to argue effectively for our cause when one encounters the victims of the occasional neglectful, unscrupulous, or arrogant physician. In spite of its broad scientific base, medical practice is an art. No amount of scientific knowledge can justify lack of compassion, fairness, or human understanding.

What then should our course be for the future? This future will be determined largely in legislative chambers. The Medical Society of New Jersey has a Council on Legislation and retains a legislative analyst. Periodically, your *Newsletter* lists bills pending in Trenton that affect our practice, and indicates whether the Society looks upon such bills with favor, actively opposes them, or takes no position—giving reasons for the point of view in each case. Unfortunately, many doctors do not read these publications. Therefore my first recommendation is that we educate ourselves and take the time to become familiar with our own problems. We cannot educate the public unless we ourselves are informed.

Second, our judicial mechanism must be utilized more fully. Our members and the public must be made more aware of the functions of our county judical committees. Misunderstandings between doctor and patient can be settled through the actions of these committees.

Third, our emergency service must be improved, and we must take the initiative in seeing that community medical emergency services are created. And unless something is done to encourage doctors to become general practitioners, I see a steady worsening of this problem.

Fourth, we must strive to create an atmosphere of cooperation in which to work. To do this we need public relations help. Perhaps at county level we should hire trained public relations workers to help us. I should like to

offer a note of caution here, however. Hiring public relations counsel will not automatically solve all of our problems. Actually, it will mean *more work,* not less, for our public relations committee; but results will justify such an undertaking. After all, medicine is a peculiar, specialized field with peculiar problems, and even a public relations expert needs orientation and guidance from someone with a medical background.

In May 1961, I listened with great interest to the President's address given by Dr. Jesse McCall. He recounted an instance in which he was asked how he found time to be active in the affairs of the Medical Society. His answer was that one doesn't find time, one *takes* time.

In closing, may I say to you that the component medical society is the organization in which our strength lies. If we take time, support it vigorously, and keep it strong, our voice will be heard. If we are inactive or indifferent, we shall, inevitably, awaken one morning to find—to our grief and society's loss —that all that is necessary for tyranny to succeed is that good men do nothing.

168 Madison Avenue

Meals on Wheels

House-bound patients unable to prepare their own meals may find life still livable if they can find a "meals on wheels program." A detailed account of where to find such services, or how to organize one, is available in an 86-page report from the National Council on Aging, summarizing a study made possible by the U.S. Public Health Service. The report will aid agencies in providing for delivery to the homes of ill, handicapped, and other persons of one hot meal a day, a cold supper, and even breakfast.

There already is a need "of considerable magnitude" throughout the country, including rural areas, for this kind of nonprofit "Meals-on-Wheels" service. The need will increase with population growth, people living longer, and the trend for older persons to live alone or with elderly relatives.

Home-delivered meals prepared, packaged, and delivered under the supervision of a nutritionist have an appropriate place in therapy, promotion, and maintenance of physical, mental, and social well-being. Programs can be well-structured, operated, and financed through voluntary or public funds, or a combination of both. This brochure will prove useful to administrators and staff of agencies and institutions already providing, or planning to provide, portable meals. These facilities include hospitals, nursing homes, homes for the aged, chronic disease institutions, public health nursing agencies, casework agencies, settlement houses, community centers, health and welfare departments, and rehabilitation agencies.

The report includes suggestions about the people to be served; the development of criteria for admission; auspices; staffing; food service; and financing. The brochure even includes six case histories that are convincing of the need for meals services.

Home-Delivered Meals for the Ill, Handicapped, and Elderly may be obtained at $1.50 per copy from The National Council on the Aging, 104 East 25th Street, New York, N.Y. 10010. Quantity prices are available upon request.

STATE ACTIVITIES

Trustees' Minutes

July 18, 1965

A regular meeting of the Board of Trustees was held on Sunday, July 18, 1965, at the Executive Offices. For the further information of our members, detailed minutes are on file with the Secretary of each component society. A summary of the significant actions follows.

President's Report . . . Noted that the President has accepted membership on: (1) Citizens Committee for Higher Education in New Jersey . . . a non-profit group interested in focusing attention on the need to break through the financial barriers which limit higher education in New Jersey; and (2) Citizens Committee to publicize and support the State Health Aid Bill (S-150 of 1965).

Meetings . . . Authorized attendance at meetings, with expenses paid, as indicated:

1. Professional Convention Management Association . . . August 5 in Chicago . . . Administrative Secretary (officer and member of the Board of Directors of PCMA).

2. AMA PR Institute . . . August 19-20 in Chicago . . . President, Executive Director, Chairman of the Council on Public Relations.

3. Institute on Medical Care . . . September 23 in Princeton . . . President, President-elect, Executive Director.

4. Civil Defense Regions 1 and 2 . . . August 7-8 in Washington . . . Chairman of the Special Committee on Disaster Medical Care.

Medical Ethics and Professionalism . . . Designated the following to attend the National Congress on Medical Ethics and Professionalism, with expenses paid by the AMA, to be held in Chicago, October 2 and 3: President, Chairman of the Judicial Council, Executive Director, and Legal Counsel.

Meeting of County Presidents . . . Postponed until November 21 the reorganization meeting for 1965-66 of the Presidents of Component Societies.

Bicentennial History . . . Appointed the following committee, to expedite publication of the Society's history and to spend whatever sums are necessary to accomplish this up to a total of $30,000:

Emanuel M. Satulsky, M.D., Elizabeth
Samuel J. Lloyd, M.D., Trenton
George B. Sharbaugh, M.D., Trenton
Fred B. Rogers, M.D., Trenton
Mr. Richard I. Nevin, Trenton

Bicentennial Celebration . . . Approved the following recommendations of the Publication Committee concerning THE JOURNAL's part in the Society's forthcoming bicentennial celebration and 200th Anniversary Meeting:

1. For purposes of JOURNAL utilization, the bicentennial year will be construed as running from August 1965 through July 1966. During that year:

(a) Each issue will carry brief, varied reminders of the 200th anniversary year.

(b) All issues up to May 1966 will carry items about the Society's book, including brief advance trailers, so that members will look forward to receiving their copy.

(c) After distribution of the historical book in May, brief notices will be continued. Readers will be reminded that this book would be an ideal gift for patients, acquaintances in related professions, newspaper friends, legislators, and the like.

(d) Component societies will be urged to submit brief, interesting historical items (including pictures). These will be published on a first-come, first-published basis.

(e) The Society's Archivist-Historian (Dr. Fred B. Rogers) will select interesting historical items from the book, one or more to be published each month.

(f) Each issue will have a running head on the front cover calling attention to the Society's 200th year.

2. The gala celebration of May 1966 will be the basis for a special anniversary (commemorative) issue in July 1966.

(a) Speeches of the civic dignitaries as well as scientific presentations will be featured.

(b) An official photographer, to be engaged for the duration of the annual meeting, will take pictures of every major event. Selections from these pictures will be included in the commemorative issue.

(c) Consideration will be given to the possibility of a different cover and/or a special permanent clip-cover, to be available at cost through component societies.

(d) Advertising representatives will solicit additional "good will" advertising by mentioning specific long-time affiliations with the Society or by calling to the attention of a firm its mention in the historical book (i.e., Borden's Eagle Brand was recommended by physicians in the 1880's as the first reliable artificial food for babies, etc.).

3. The August 1966 issue will become the official "Transactions Issue."

AMA Delegates . . . Authorized a letter to the American Medical Association, expressing the Society's willingness to send a representative to the AMA Board meeting when legislation concerning the community mental health centers (HR-2985 and S-513) is discussed.

1966 Golden Merit Award . . . Approved the following recommendations of the Council on Public Relations:

1. That the conferral ceremony be scheduled for 2:00 p.m.

2. That a group picture be taken as well as individual pictures.

3. That county group pictures be taken whenever more than one recipient is present from the same county.

4. That these group pictures be taken in the Rutland Room after the ceremony. During this interval, the families and guests of the recipients can be invited to move over to the Derbyshire Lounge for the reception.

Intra-hospital Infections . . . Received the report of the Joint Committe on Intra-hospital Infections, to which representatives from the Society, State Department of Health and Communicable Disease Center, New Jersey State Nurses' Association, and New Jersey Hospital Association were present:

The committee is primarily concerned with the problem of hospital infections. Its activity should be concentrated on surveillance of institutional infections and the development of a demonstration program. As a preliminary activity, the primary demonstration centers considered were the Clara Maass Memorial Hospital, Belleville, the Princeton Hospital, Newark City Hospital, and probably the Jersey City Medical Center. It was suggested that a symposium be held this fall, under the auspices of the State Department of Health and The Medical Society of New Jersey: "Basic Principles of Hospital Surveillance for Infectious Diseases." the program to cover the individual problems of (1) post-operative infections; (2) infectious diarrhea; (3) urinary tract infections; (4) hepatitis; (5) central nervous system infections; and (6) the activity of the hospital infection committee.

It was *recommended* that Commissioner Kandle be requested to invite from *all* New Jersey hospitals the medical director, chiefs of medicine, surgery, obstetrics, and pediatrics, and members of each hospital infection committee.

It was suggested that the symposium include a discussion of the general problems of infection surveillance in a hospital; specific problems involved in post-operative infections, pediatric infections, hepatitis; and role of the nurse in combatting infections within the hospital.

The committee summarized its actions as follows:

1. Chairman Albano to write Commissioner Kandle requesting that the State Department of Health sponsor a fall symposium;

2. Chairman Albano to get in touch with a New Jersey pharmaceutical company relative to underwriting the cost of the luncheon on the day of the seminar;

3. Dr. Dougherty, in the interval, to prepare a preliminary program for consideration of the joint committee;

4. If approved, the State Health Department make arrangements for a suitable meeting place, speakers, and other arrangements pertinent to the undertaking.

. . . Approved authorization for the Society's participation as a co-sponsor of the symposium

Mental Health Conference . . . Acknowledged, with commendation, the detailed report from Dr. Eugene V. Resnick of Paramus, who attended as the Society's representative the Mental Health Planning Conference, held in Princeton last month.

Osteopathic Question . . . Reactivated the Special Committee on the Osteopathic Question, to review the entire situation of osteopathy and medicine and to recommend a policy statement which MSNJ can forward to the AMA:

Emanuel M. Satulsky, M.D., Elizabeth
Louis K. Collins, M.D., Glassboro
John J. Bedrick, M.D., Bayonne

VA Contract . . . Authorized the new VA contract, effective July 1, 1965.

National Opinion Research Center . . . Discussed complaints received from members concerning the personal questions asked in conjunction with the NORC survey.

Directed that the Society's displeasure be brought to the attention of NORC, the State Department of Health, and the AMA, with

the notation that future cooperation will not be forthcoming if such a situation should recur.

Liability Insurance Rates . . . Noted that the New Jersey State Department of Banking and Insurance (on request of the National Bureau of Underwriters) has approved a 20 per cent increase in professional liability insurance rates.

Bicentennalia

Hallowed Ground: Old St. Peter's Church, Perth Amboy

Old St. Peter's Church, at Rector and Gordon Streets in Perth Amboy, has historic ties with The Medical Society of New Jersey. Dating from 1685 and the oldest Episcopal parish in New Jersey, it has witnessed important events in both colony and state. A link with the Medical Society dates back two centuries for its first president. The Rev. Dr. Robert McKean, a clerical physician, served as Rector of the Church from 1763 to 1767.

Born in Chester County, Pennsylvania, in 1732, Robert McKean studied medicine and theology and was ordained to the priesthood of the Anglican Church by the Bishop of London in 1757. Returning as a missionary to Christ Church, New Brunswick, the same year, he served for six years in that charge. He practiced medicine and taught school in connection with his parochial duties.

In 1761 Dr. McKean married Mabel Graham Antill, daughter of a prominent New Jersey councilor. Two years later he moved to Perth Amboy, during the flourishing Colonial period of that city. He practiced medicine in Middlesex County and in 1766 became a founder and first President of The Medical Society of New Jersey. Re-elected the following year, he held that office until his untimely death from tuberculosis at the age of 35.

Taken ill with *phthisis pulmonalis* in 1765, Dr. McKean sought professional advice from Dr. John Morgan of Philadelphia, founder in that year of the first medical school in the colonies. The sickness progressed and Robert McKean died on October 17, 1767. His brother, Thomas McKean (1734-1817), later a signer of the Declaration of Independence and Governor of Pennsylvania, erected a monument over Robert's grave. This epitaph can be read today in St. Peter's Churchyard.

In 1923, on the 225th anniversary of St. Peter's Church in Perth Amboy, The Medical Society of New Jersey dedicated a tablet in the sanctuary to the memory of its initial leader. This memorial, bearing an inscription and the seal of the Medical Society, is on the west wall near the entrance to the church. A visit to historic St. Peter's Church, an edifice of aged stone and beautiful stained glass, can inspire members of the medical profession.

Fred B. Rogers, M.D.

Extension of Radiation Protection Code

The Commission on Radiation Protection has a new Code effective February 1, 1965. It provides for the licensing for use and possession of *all* radioactive materials not subject to such similar licensing by the Atomic Energy Commission. Those radioactive materials subject to New Jersey licensing include radium, radon, natural polonium 210, and all radioisotopes that have been produced in particle accelerators.

All persons using sources of radiation in New Jersey should now familiarize themselves with the new Code. Those using radioactive materials requiring licenses by New Jersey should immediately contact the Radiologic Health Program for information on licensing procedures. If any questions arise regarding the new radioactive materials licensing requirements, or any other Code requirements, please con-

tact the Radiologic Health Program in writing or *via* telephone at 609-292-4090.

For a copy of the Code or for more information, write to the Radiologic Health Program at P.O. Box 1540, Trenton, New Jersey 08625.

Rehabilitation Report Available

Last March, the New Jersey Department of Labor and Industry, in cooperation with the National Institutes on Rehabilitation, held an "Institute" in Trenton focused on problems related to rehabilitating the disabled worker.

A 48-page brochure summarizing the findings and recommendations is now available, without charge, to readers of this JOURNAL. For your copy, write to Division of Workmen's Compensation, Post Office Box W, John Fitch Plaza, Trenton, N.J. 08625.

Edited by Monroe Berkowitz, the brochure includes chapters on administrative, medical, supervisory, employment, and personnel phases of the problem. Among the contributors are Arthur Bernstein, M.D., Joseph LePree, M.D., E. J. Carlin, M.D., Earl F. Hoerner, M.D., Marvin Bierenbaum, M.D., C. C. Buford, M.D., Alan A. Dun, M.D., Alan Flesichman, M.D., Alvin Florin, M.D., Martin Lasoff, M.D., and Max Singer, M.D.

1965-66 OFFICIAL INTERMEDIARIES BETWEEN MEDICAL SOCIETY OF NEW JERSEY AND THE NEW JERSEY SPECIALTY SOCIETIES

Allergy Society, New Jersey
Arthur A. Goldfarb, M.D., *Secretary* ... Teaneck

Anesthesiologists, New Jersey State Society of
Anthony T. Rose, M.D., *Secretary* Paterson

Chest Physicians, New Jersey Chapter, American College of
Meyer I. Weissman, M.D., *Secretary* ... Elizabeth

Clinical Research, New Jersey Chapter, American Federation for
Theodore A. Dull, M.D., *Secretary* ... Bloomfield

Dermatological Society, New Jersey
Jean Cramer, M.D., *Secretary* ..... Elizabeth

Diabetes Assaciatian, New Jersey
Gabriel Pickar, M.D., *Secretary* Bloomfield

Gastroenterological Society, New Jersey
Kendrick P. Lance, M.D., *Secretary* Paterson

General Practice, New Jersey Academy of
Nathan J. Plavin, M.D., *Secretary* East Orange

Industrial Medical Assaciatian af New Jersey
Harley G. Shepard, M.D., *Secretary* ... Princeton

Internal Medicine, New Jersey Society of
Murray D. Shepp, M.D., *Secretary* Trenton

Neurapsychiatric Association, New Jersey
Laura E. Morrow, M.D., *Secretary* ..... Passaic

Obstetrical and Gynecalagical Saciety, New Jersey
Eugene J. Slowinski, M.D., *Secretary* ... West Orange

Ophthalmalagy and Otolaryngalagy, New Jersey Academy of
John Scillieri, M.D., *Secretary* Paterson

Orthopaedic Society, New Jersey
Fred J. Knocke, M.D., *Secretary* Flemington

Patholagists, New Jersey Society af
Harry H. Stumpf, M.D., *Secretary* ..... Montclair

Pediatrics, New Jersey Chapter, American Academy of
Phoebe Hudson, M.D., *Secretary* Westwood

Physical Medicine and Rehabilitatian, New Jersey Society for
Percy L. Miller, M.D., *Secretary* Spring Lake Heights

Practalagic Saciety, New Jersey
David Levy, M.D. Paterson

Psychaanalytic Saciety, New Jersey
Bernard German, M.D., *Secretary* East Orange

Radialagical Society af New Jersey
Stephen Dewing, M.D., *Secretary* Flemington

Rheumatism Assaciatian, New Jersey
Lawrence J. Denson, M.D., *Secretary* Hackensack

Surgeans, New Jersey Chapter, American College af
Felix H. Vann, M.D., *Secretary* Englewood

Surgeons af New Jersey, Society af
Raphael S. Cantini, M.D., *Secretary* Plainfield

1965-66 SPECIAL AND LIAISON REPRESENTATIVES AND COMMITTEES

Aged, New Jersey Joint Council to Improve the Health Care of the

David Eckstein, M.D., *Chairman* ..... Trenton
Matthew E. Boylan, M.D. ..... Jersey City
John B. Fuhrmann, M.D. ..... Flemington
John F. Kustrup, M.D. ..... Trenton
Equal Representation from:
New Jersey Hospital Association
New Jersey State Dental Society
New Jersey State Nurses' Association
Licensed Nursing Homes of New Jersey, Inc.

Air Pollution, Advisory Committee to Commission on

Special Committee on Air Pollution

American Medical Association — Education Research Foundation

(N.J. Chairman)
Chairman, Medical Student Loan Fund Committee
Luke A. Mulligan, M.D. ..... Leonia

Audit Review Committee

(1964-65 Audit)
Frank J. Hughes, M.D., *Chairman* ..... Gloucester
Louis F. Albright, M.D. ..... Spring Lake
Joseph P. Donnelly, M.D. ..... Jersey City
Samuel J. Lloyd, M.D. ..... Trenton
Nicholas E. Marchione, M.D. ..... Vineland
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Daniel F. Featherston, M.D., *Treasurer* ..... Asbury Park
Thomas C. DeCecio, M.D., *Chairman, Committee on Finance and Budget* ..... Cliffside Park

Bicentennial History (1966)

Fred B. Rogers, M.D., *Historian-Archivist* ... Trenton
Emanuel M. Satulsky, M.D. ..... Elizabeth
Samuel J. Lloyd, M.D. ..... Trenton
George B. Sharbaugh, M.D. ..... Trenton
Mr. Richard I. Nevin, *Executive Director* .... Trenton

Bicentennial Scientific Program, Committee to Evolve (1966)

John J. Bedrick, M.D. ..... Bayonne
Joseph R. Jehl, M.D. ..... Clifton
John F. Kustrup, M.D. ..... Trenton
Nicholas A. Bertha, M.D. ..... Wharton
Jerome G. Kaufman, M.D. ..... Maplewood

Blood Bank Commission of New Jersey

Authorized agent of Medical Society in approved Blood Bank Programs

Blood Bank Commission Representatives

Jerome G. Kaufman, M.D. ..... Maplewood
John J. Torppey, M.D. ..... Newark

Blue Cross and Blue Shield Plans of New Jersey, Permanent Committee on

Nicholas A. Bertha, M.D., *Chairman, Board of Trustees* ..... Wharton
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Equal Representation from:
Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Board of Control, State Department of Institutions and Agencies

(appointed by Governor—term, 8 years)
Frank J. Hughes, M.D. (June 1971) ..... Gloucester

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Mr. Richard I. Nevin, *Executive Director* .... Trenton

Chronic Sick, State Advisory Council on the

(appointed by Governor—term, 3 years)
William D. Kimler, M.D.
(December 1967) ..... Haddon Heights

Civil Defense Organization, Liaison with State

Jack R. Karel, M.D., *Chairman, Committee on Disaster Medical Care* ..... Hillside

Crippled Children and Adults, Statewide Sponsoring Committee of New Jersey Society for

John J. Bedrick, M.D., *President* ..... Bayonne

Crippled Children Commission, State

(appointed by Governor—term, 5 years)
Frederick G. Dilger, M.D. (May 1966) ... Hackensack

Diabetes Detection Drive, 1965 — Liaison Representative

John J. Torppey, M.D. ..... Newark

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2nd District—
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5th District—
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Education, Liaison with State Department of

Robert E. Jennings, M.D., *Chairman, Special Committee on Child Health* ..... South Orange

Emotionally Disturbed Child, Advisory Council on — to State Department of Education

(appointed annually by Commissioner of Education)
Robert E. Jennings, M.D.
(November 1965) ..... South Orange

Epilepsy, Advisory Panel on — to Director of Motor Vehicles

Francis A. Wood, M.D. ..... Newark

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(Bylaws, Chapter IV, Section 5b.)

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(appointed by Board of Control—term, 4 years)
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Edwin H. Albano, M.D., *Chairman* — East Orange
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New Jersey Hospital Association
New Jersey State Nurses' Association

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Conference Committee on Inter-Relations with the

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Equal Representation from:
Supreme Court Committee on Relations with the Medical Profession

Lay Health Organizations and Paramedical Groups, Official Intermediaries with

Members of the Council on Public Health as assigned by the chairman.
(Assignment of official intermediaries from The Medical Society of New Jersey to lay health organizations and/or paramedical groups does not imply endorsement of the organization/group or its program.)

Legislation, Federal Keymen

15 Congressional District Keymen
1 Senatorial Keyman

Legislation, State Keymen

Keymen in 21 Counties

Medical Assistants, New Jersey Association of

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Equal Representation from:
New Jersey Hospital Association
New Jersey State Nurses' Association

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(Where number of representatives from other organization is larger than number of Medical Society representatives, the latter will be increased from the Presidential Officers to equal the former.)

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Joseph P. Donnelly, M.D. — Jersey City
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(per Medical-Surgical Plan of New Jersey Bylaws)
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Medicare Fiscal Agent

Medical-Surgical Plan of New Jersey

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Thomas C. DeCecio, M.D. — Cliffside Park
L. Samuel Sica, M.D. — Trenton

Membership Directory, Special Committee on

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Nicholas A. Bertha, M.D. — Wharton
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Mr. Richard I. Nevin, *Executive Director, Ex-Officio* — Trenton
Mr. Robert H. Lambert, *Office Manager, Ex-Officio* — Trenton

Mental Health Planning Study Group — State

Joseph R. Jehl, M.D., *Executive Secretary, Task Force on Medical Practice in Hospitals* — Clifton

Motor Vehicles, Liaison with State Division of

William L. Sprout, M.D., *Chairman, Special Committee on Traffic Safety* — Salem

Neurologic Diseases, Advisory Council on

(to New Jersey Consultation Service for Convulsive Disorders)
Robert S. Garber, M.D., *Chairman, Committee on Mental Health* — Belle Mead

New Jersey College of Medicine, Student AMA, Liaison with

Joseph P. Donnelly, M.D. — Jersey City

Nursing Education and Recruitment, Permanent Committee on

Jesse McCall, M.D., *Chairman* — Newton
George E. Barbour, M.D. — Somerville
William P. Mulford, M.D. — Beverly
Lewis E. Savel, M.D. — South Orange
Mr. Richard I. Nevin, *Executive Director, Ex-Officio* — Trenton
Equal Representation from:
New Jersey Hospital Association
New Jersey League for Nurses
New Jersey State Nurses' Association
Administrators of Nursing Schools
2 Advisors from State Department of Education

Nutrition Council, Liaison with New Jersey

S. William Kalb, M.D. — Newark

Osteopathic Question, Special Committee on

Emanuel M. Satulsky, M.D. — Elizabeth
Louis K. Collins, M.D. — Glassboro
John J. Bedrick, M.D. — Bayonne

Parents and Teachers, New Jersey Congress of, Liaison with

Joseph R. Jehl, M.D. — Clifton

Pension Plan, Special Committee on

Thomas C. DeCecio, M.D., *Chairman, Committee on Finance and Budget* — Cliffside Park
John J. Bedrick, M.D., *Chairman, Special Committee on House Maintenance, etc.* — Bayonne
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Post-Graduate Medical Education Study Committee

(with Academy of Medicine)
Sherman Garrison, M.D., *Chairman, Committee on Medical Education* — Bridgeton

Public Health Association, New Jersey

Louis S. Wegryn, M.D. (Delegate) — Elizabeth
Mr. Richard I. Nevin (Alternate) — Trenton

Public Health Association, New Jersey Medical Care Committee

John J. Bedrick, M.D. — Bayonne

Public Health Council, State Department of Health

Henry L. Drezner, M.D. (1971) — Trenton

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Joseph R. Jehl, M.D. — Clifton
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Quackery, Committee on

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Charles B. Norton, M.D. — Woodstown

Radiation Protection Commission, Consultant to New Jersey

Bernard M. Schnur, M.D. — Trenton

Rehabilitation Commission, New Jersey State

Carl A. Maxwell, M.D. — Phillipsburg

Safety Council, New Jersey State

(per Council Bylaws)
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William L. Sprout, M.D., *President's representative, Chairman, Committee on Traffic Safety* — Salem

Selective Service System, Chairman of New Jersey Advisory Committee

(appointed by National Advisory Committee)
Jesse McCall, M.D. — Newton

Special Committee Structure, Study of

John J. Bedrick, M.D., *Chairman* — Bayonne
John B. Fuhrmann, M.D. — Flemington
Joseph R. Jehl, M.D. — Clifton
Nicholas E. Marchione, M.D. — Vineland
Mr. Richard I. Nevin, *Executive Director, Ex-Officio,* — Trenton

Tuberculosis Council, Liaison with State

John B. Fuhrmann, M.D. — Flemington

Widows and Orphans of Medical Men of New Jersery, Liaison with Society for the Relief of

Joseph R. Jehl, M.D. — Clifton

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

SURGERY AND GENERAL PRACTICE—Ralph N. Lee, M.D., Veterans Administration Hospital, Fort Howard, Maryland. Howard University Medical School 1960. General surgical residency. Available immediately.

NEUROSURGERY—Mario Ludmer, M.D., 256 Highland Avenue, Pittsburgh, Pa. 15229. University of Buenos Aires School of Medicine 1956. Board eligible. Available immediately.

GENERAL PRACTICE—Edward G. Krug, M.D., 142 Merson Drive, Buchanan, Michigan 49107. Wayne State University 1958. Available immediately.

PATHOLOGIST—James Ernst Haines, M.D., Worcester Foundation for Experimental Biology, 222 Maple Avenue, Shrewsbury, Massachusetts. Stanford University Medical School 1955. Board certified in Anatomical Pathology. Board eligible in Clinical Pathology. Available October 1966.

OBSTETRICS AND GYNECOLOGY—Birute S. Preikstas, M.D., 729 West Corrington Avenue, Peoria, Illinois 61604. Eberhard-Karls University, Tuebingen, Germany 1949. Specialty training in obstetrics and gynecology. Available immediately.

ASSISTANT OR ASSOCIATE PATHOLOGIST—C. H. Makris, M.D., 26 Forestdale Avenue, Holyoke, Massachusetts 01041. Athens (Greece) 1952. Board eligible in pathology. Licensed in New Jersey. Available immediately.

ANESTHESIOLOGY—Neal H. Isil, M.D., R. R. #1, Box 161, Fort Madison, Iowa 52627. University of Istanbul (Turkey) 1955. Board Certified. Available immediately.

INTERNAL MEDICINE—Michael A. Bokat, M.D., The Clinical Unit of the Tufts-New England Medical Center, 171 Harrison Avenue, Boston, Massachusetts 02111. Albert Einstein College of Medicine 1961. Board qualified, internal medicine; training in endocrinology. Available immediately.

Leonard Gorkun, M.D., 14 Walnut Parkway, Montclair. Seton Hall 1960. Three-year residency. Available July 1, 1966.

CLINICAL PRACTICE—George V. Clift, M.D., 217 William Street, Minoa, New York. Columbia University 1958. Board eligible. Internal Medicine—training endocrinology. Available July 1966.

SURGERY—David M. Hirsch, Jr., M.D., 2835 Webb Avenue, Bronx, New York 10468. University of Chicago 1959. Board eligible. Available January 1966.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

BICENTENNIAL CELEBRATION

Annual Meeting

Friday-Wednesday
May 14-18, 1966
Haddon Hall, Atlantic City

Scientific Meeting

sponsored by
The Medical Society
of New Jersey
and
Rutgers Medical School
Saturday, October 1, 1966
Rutgers University
New Brunswick

PLAN TO ATTEND

COMMUNITIES SEEKING PHYSICIANS

The following communities have written to the Executive Offices of MSNJ seeking information on possible physicians to fill vacancies. The information listed below has been supplied by the communities and verified by the counties. If you are interested in any further information concerning these communities, we suggest you make inquiries directly of them.

LONG VALLEY (WASHINGTON TOWNSHIP) — Morris County, population of 4500. General practitioner preferably; or obstetrician-gynecologist or pediatrician. One other general practitioner in community. Contact Mrs. David Bressler, Coleman Road, Long Valley, New Jersey; or phone 201-876-3757.

SEVERAL IN SALEM COUNTY, YOUNG GENERAL PRACTITIONERS—New Jersey Chapter of the American Academy of General Practice offers individual services to counsel and introduce to the communities interested physicians. Contact William L. Sprout, M.D., 69 Market Street, Salem, New Jersey

BICENTENNIAL CONVENTION

Saturday-Wednesday, May 14-18, 1966

Friday, May 13, 1966

Morning — Convention Office and Press Room open, Sun Porch, Lounge floor

5:00 p.m. — Board of Trustees, Bakewell Room

7:00 p.m. — Dinner, Board of Trustees, Derbyshire Room, First floor

Saturday, May 14, 1966

All Day — Installation of exhibits, Exhibit Hall

10:00 a.m. — Registration opens (10:00 a.m.-4:30 p.m.), Stair Hall, Lounge floor

1:30 p.m. — Golden Merit Award Lounge, Rowsley Room, First floor

2:00 p.m. — Golden Merit Award Ceremony, Rutland Room, First floor

2:30 p.m. — Golden Merit Award Reception, Derbyshire Room, First floor

4:00 p.m. — House of Delegates, Vernon Room, Lounge floor, To be followed by (tentatively) MSP Discussion

8:00 p.m. — Nominating Committee, Bakewell Room

(The usual reception and Board dinner on Saturday evening will not be held in 1966)

Sunday, May 15, 1966

Morning — Installation of exhibits, Exhibit Hall

9:30 a.m. — Registration, Exhibit Hall (transferred), (9:30 a.m.-4:30 p.m.)

11:00 a.m. — 9 Reference Committees, Bakewell Room, First floor; Rowsley Room, First floor; Derbyshire Room, First floor; Rutland Room, First floor; West Room, Tower floor; Mandarin Room, Tower floor; Room 1333, Tower floor; Room 1335-37, Tower floor; Room 1344, Tower floor

12:00 noon — Exhibits open, Exhibit Hall (12:00 noon-5:00 p.m.)

2:30 p.m. — House of Delegates (school room setup), Pennsylvania Room

3:30 p.m. — Session on Medicine and Religion, Vernon Room

6:00 p.m. — Reception for President-Elect, Pennsylvania Room

Monday, May 16, 1966

9:00 a.m. — Registration (9:00 a.m.-4:30 p.m.), Exhibit Hall

9:00 a.m. — Exhibits open (9:00 a.m.-5:00 p.m.), Exhibit Hall

9:30 a.m. — 4 Scientific Sessions, Vernon Room, Lounge floor; *Garden Room, Lounge floor; *Rutland Room, Lounge floor; *Solarium, Lounge floor

2:00 p.m. — 4 Scientific Sessions, Vernon Room, Lounge floor; *Garden Room, Lounge floor; *Rutland Room, Lounge floor; *Solarium, Lounge floor

6:00 p.m. — Reception and Buffet Dinner for Technical Exhibitors, Pennsylvania Room

Tuesday, May 17, 1966
BICENTENNIAL DAY

9:00 a.m. — Registration (9:00 a.m.-4:30 p.m.), Exhibit Hall

9:00 a.m. — Exhibits open (9:00 a.m.-5:00 p.m.), Exhibit Hall

9:30 a.m. — Scientific Program, Pennsylvania Room

12:30 p.m. — Luncheon, Vernon Room

2:30 p.m. — Session on History and Medicine, Pennsylvania Room

5:00 p.m. — Exhibits close, Exhibit Hall

5:30 p.m. — Reception by Atlantic City Convention Bureau, Lounge floor (Vernon Room, Garden Room, Solarium and English lounge)

7:00 p.m. — Dinner, Pennsylvania Room

Wednesday, May 18, 1966

9:00 a.m. — Registration (transferred), Stair Hall, Lounge floor (9:00 a.m.-2:00 p.m.)

10:00 a.m. — House of Delegates (school room setup) Pennsylvania Room

1:00 p.m. — Luncheon for delegates, Vernon Room*

2:00 p.m. — House of Delegates (continued, if required), Pennsylvania Room

2:00 p.m. — Registration closes, Stair Hall, Lounge floor

3:00 p.m. — Board of Trustees, Bakewell Room, First floor

3:00 p.m. — Convention Office and Press Room close, Sun Porch

(*) Pennsylvania Room, if can be partitioned

OBITUARIES

Dr. Jennie D. Beaver

One of the pioneer women physicians of the country, Dr. Jennie Dean Beaver of Morristown, died there on August 2, 1965 at the grand age of 79. Born in Pennsylvania, she received her M.D. at Cornell in 1910. After an internship at the University Hospital, Dr. Dean took a three-year residency in internal medicine and pathology at the Methodist Episcopal Hospital in Philadelphia.

She came to Morristown in 1913 to organize the first clinical laboratory at the Memorial Hospital and also to serve as anesthesiologist there. She became school physician to several Boards of Education in adjacent communities. During World War I, she tried to get a medical corps commission—but they weren't taking any women physicians then, so she joined the Red Cross staff and did her work as a physican at numerous posts between Cairo and Paris. There she met Rex P. Beaver, a captain in the British Army; and right after the war, Dr. Dean became Dr. Beaver.

Mustered out in 1920, she served the people of the Morristown area for the next 30 years. She was associated with Dr. Will Cook Spain in his pioneer work in allergy. She became a member of the N.J. Allergy Society when it was first organized. In 1960 she was one of the laureates of our Society's Golden Merit Award.

Dr. Harold C. Geiger

Dr. Harold C. Geiger, a Passaic County general practitioner, died suddenly of a heart attack on June 7, 1965. Born in Pennsylvania in 1907, he was graduated from the medical school of Temple University in 1935. After completing his internship, he came to West Milford for private general practice; and except for his military duties during World War II, he served the people of that area from 1936 until his sudden death in 1965. He was a senior attending physician at the Franklin Hospital in Franklin, New Jersey and surgeon to the local police department.

Dr. Robert Shipman

At the untimely age of 50, Dr. Robert Shipman died suddenly on May 29, 1965. He was a 1940 graduate of New York Medical College, attending pediatrician at all three Jersey City Hospitals, and a diplomate in pediatrics. He entered the army immediately after Pearl Harbor rising rapidly in grade from Lieutenant to Lieutenant Colonel, eventually becoming chief medical officer of the distinguished 77th Division. Dr. Shipman was Professor of Pediatrics at the New Jersey College of Medicine and Dentistry.

Health Facilities Planning Directory

The American Medical Association has published the first directory of health facility planning agencies in the United States. This 196-page directory lists planning agencies by location; purposes; organization; relationships with medical associations, hospital groups; geographic description of service area; type of research program; and publications.

The directory also contains a statistical supplement which identifies the elements of the various areawide planning regions in terms of physician distribution by type of practice, hospital information, county characteristics, and county societies.

Single copies are available without cost to members of The Medical Society of New Jersey. Bulk prices are available upon request. Send your request to the Department of Hospitals and Medical Facilities, AMA, 535 North Dearborn Street, Chicago, Illinois 60610.

ANNOUNCEMENTS

Course in Medical Hypnosis

Columbia University is sponsoring a course in hypnosis for physicians, which includes case demonstrations, practice sessions, and seminars. The course will be given on seven consecutive Saturdays, starting on October 2, and will be held from 10:00 a.m. to 5:00 p.m. The course is under the direction of Dr. Herbert Spiegel, and the tuition fee is $175. For applications, write to Melvin D. Yahr, M.D., College of Physicians and Surgeons, 630 West 168th Street, New York, New York 10032.

Diabetes Symposium

The 13th Annual Diabetes Symposium is scheduled for Saturday, October 16, at the Barbizon Plaza, 104 Central Park South in New York City. A $5 registration fee is required. The morning program, which starts at 9:30 a.m., will discuss clinical and practical aspects of diabetes. At 2:30, the afternoon session will open with a discussion of diabetes in pregnancy. For more information, write to New York Diabetes Association at 104 East 40 Street, New York City 10016.

Seminar on Nutrition

On Monday afternoon, October 18, the tenth Annual Conference on Nutrition and Metabolism will be held at the County Medical Society building, 2100 Spring Garden Street in Philadelphia. This year's session will concentrate on obesity in all its aspects. For detailed program, write to Dr. Michael Wohl, 1727 Pine Street, Philadelphia 3.

Office Psychiatry for the Physician

Dr. James E. McCormack, Dean and President of the New Jersey College of Medicine, announces an 8-meeting Thursday morning course in office psychiatry for the nonpsychiatric physician. The first session is on October 21, the last on December 16. Meetings are held at the Medical school building, 24 Baldwin Avenue, Jersey City. There is no fee for this course, which is supported by a grant from the National Institute of Mental Health and under the supervision of Dr. Harry LaBurt, chairman of the Department of Psychiatry. For details, write to Dr. Gerald H. Rozan, Department of Psychiatry, 24 Baldwin Avenue, Jersey City 07304. Each session runs from 9:30 a.m. to noon, and the topics covered are:

Oct. 21. The physician himself as a clinical tool.
Oct. 28. Overview of psychiatric entities in office practice.
Nov. 4. Interviewing the patient and establishing a diagnosis.
Nov. 11. Handling the depressed patient. Anticipating suicide.
Nov. 18. Anxiety. Treatment, including chemotherapy.
December 2. Psychosomatics for the nonpsychiatrist.
December 9. Sexual problems in office practice.
December 16. Supportive psychotherapy. Summary and retrospect.

New New Jersey Mental Health Code

All physicians who are concerned with hospitalizing the mentally ill and mentally retarded will want to hear this authoritative discussion of the application of New Jersey's new mental health code, which went into effect late last month. The meeting will be held under the auspices of the Academy of Medicine of New Jersey and the New Jersey Neuropsychiatrc Association on Wednesday evening. September 29, at the Cambridge Inn in Paramus. The meeting place is located at Garden State Plaza (Route 4). The program starts promptly at 8:30 p.m. For reservations and further details, write to Mrs. M. Claire Wagner at 149 Ellwood Street, Trenton, New Jersey.

Diabetes Symposium

An all afternoon colloquium on diabetes will be held on Wednesday, September 29 from 2 to 5 p.m. at the Mountainside Hospital in Montclair. The first part of the afternoon will be devoted to problems in acid-base metabolism and the second part to pre-diabetic patterns. This is sponsored by the Academy of Medicine of New Jersey, the New Jersey Department of Health, and the New Jersey Diabetes Association. For details, write to the Deparment of Health at P. O. Box 1540, Trenton, New Jersey.

BOOK REVIEWS

Pediatric Procedures. By Walter T. Hughes, Jr., M.D. Philadelphia, 1964, Saunders. Pp. 208, illustrated. ($7.50)

Dr. Hughes has provided a top-notch volume of great value to anyone practicing pediatrics as a speciality, as a part of a general practice, or to members of a hospital house staff. To interns particularly it should be very useful, because it spells out in detail the steps in the many procedures which he has described. These descriptions relieve the attending physician of the minutiae so often necessary in training young physicians.

The volume will be read with profit by the older practitioner who has used many of the technics described, but who has become "rusty" in their application.

The one point which I emphasize is the importance of proper immobilization of the patient. Dr. Hughes also stresses this. So often I find this one item neglected to such a degree that many simple procedures become very frustrating and time-consuming.

Put this on your pediatric ward and save yourselves trouble.

JOSEPH R. JEHL, M.D.

History of Surgical Anesthesia. Thomas E. Keys. 1963, Dover Publications. New York. Pp. 193, illustrated. ($2.00)

This is a sturdy paperback reprint of a well written history of anesthesia, which originally appeared in 1946. It is a concise survey of events in the development of methods of eliminating pain, beginning in ancient Greece and Egypt and continuing through the centuries. Included is the development of local, regional and spinal anesthesia, intravenous and rectal anesthesia, physiologic and pharmacologic factors, anesthetic apparatus and related matters. Beautifully illustrated, it includes an extensive chronology of major events in the history of anesthesia and a vast bibliography. Written in non-technical language, it provides interesting reading for the general reader as well as the professional man alike.

STEPHEN J. SOPKIA, M.D.

Proceedings of World Forum on Syphilis and Other Treponematoses. Washington, D.C., 1964, U.S. Department of Health, Education, and Welfare. Pp. 521. ($4.00)

This volume records papers read at the World Forum on Syphilis and Other Treponematoses sponsored by our Public Health Service. The title of "other Treponematoses" could well have been eliminated, as the text deals largely with syphilis.

Organization of the book is commendable in that each author's presentation is presented in abstract form in English, French, and Spanish at the head of each paper. This enables one to assimilate the essayist's ideas without detailed reading. The general text is easily readable and contains much information of value.

The Forum was to attempt to establish a program by which syphilis might be eradicated. The reviewer cannot, however, agree completely with all the thoughts expressed. It is recommended that "physicians should be given more extensive training in diagnosing and treating infectious syphilis." In the present age of medical specialization, this is practically impossible. It is suggested that health department officials "must have personal contacts with hospital staffs and educate them on syphilis." Education is a two-way path. The reviewer can only deplore the trite statement that "venereal disease patients need psychological support to make them feel more secure as persons." The modern spelling of the negative spinal fluid and the substitution of negaspinal fluid is unforgivable in a volume of this size. The use of penicilloylpolylycine as an intradermal skin test for detection of penicillin allergy may be of some value and perhaps should have wider use in general practice.

Certain statements deserve wider dissemination; namely, it is of interest to note that among 1,000 patients with positive reagin blood tests, 72% of the white and 96.6% of the colored patients were found to be infected with syphilis while only 20% of those with positive serology were classified as biologically false-positive reactions. Only when both the RPCF and the TIP are negative can the diagnosis of false-positive reactions be entertained in a patient with persistently positive reagin blood tests. The therapy administered long after the contraction of syphilis cannot destroy treponema that have been long-time residents in the host's body.

The history of syphilis as outlined by Dr. Raymond Forer, pp. 393 to 398 of the volume, is recommended reading for all who may be interested in the history of this fascinating disease.

THOMAS K. RATHMELL, M.D.

Fundamentals of Otolaryngology. Lawrence R. Boies, M.D., Jerome A. Hilger, M.D., and Robert E. Priest, M.D. Philadelphia, 1964, Saunders. 4th Edition. Pp. 553, illustrated. ($8.50)

This welcome fourth edition is directed mainly to undergraduate medical students and non-specialist physicians. The text is easy to read. The print is sharp and clear and distinct. The arrangement of this edition makes each topic almost a brief classic of its type. It is amazing how much information is packed into each short chapter. Many of its chapters give actual prescriptions under treatment, which makes it comparatively easy for the non-specialist to rely on a few simple well tried and well proved drugs. The authors wisely stay away from complicated procedures and explanations. All through the book there is only an occasional minor error which in no way detracts from its value.

I particularly recommend to the non-specialist (and, as a review, for the specialist) the sections on applied anatomy and physiology of the ear, nose, and throat. The sections by Dr. Hilding are particularly concise and lucid, and cover a tremendous concentration of material. The entire matter is treated compactly, clearly, and in up-to-date fashion. The brief chapter on the common cold is highly recommended as a short treatment of a particularly complex subject.

Chapter 13 offers the full text of the report of the Ad Hoc Committee on Headaches. This covers very successfully, probably, our entire knowledge of the subject of headache and neuralgia in a short but clear presentation. Any physician would be amply rewarded by a careful study of this short report.

At the end of each chapter, the reader will find references for further information. This comprehensive bibliography, for further investigation, will be of great

aid to any reader who wants to advance the frontiers of his knowledge of a particular subject.

The authors have more than fulfilled their purpose in offering to the non-specialist a concise information-packed book on otolaryngology. This is one of the best of its type. It measures up to the calibre of the previous editions. I recommend this edition to all interns, resident physicians, general practitioners, and also to the specialists in this field who wish a quick handy reference book packed solidly with good information.

HENRY Z. GOLDSTEIN, M.D.

Insight and Responsibility. Erik H. Erikson. New York City, 1964, W. W. Norton & Company, Inc. Pp. 256

The lectures in this book are intended for analytically unsophisticated audiences, and are easy to read and comprehend. However, the paper on "Reality and Historical Actuality" is difficult without an understanding of psychoanalytic literature.

The title, "Insight and Responsibility," ties together these six varied lectures into one general topic: the bringing together of psychological insight and social responsibility. For those familiar with Erikson's ideas, this will be a readable reiteration and extension of his thinking. For others, it will serve as an introduction to a most erudite individual.

The analytically oriented psychiatrist as well as the psychoanalyst will find this a worthwhile addition to his library.

STANLEY R. KERN, M.D.

Guidebook for Alcoholics: How to Succeed Without Drinking. Drake Weston, Ph.D. New York, 1964, Exposition Press Inc. Pp. 136 ($3.50)

The information, instruction, and advice presented in Mr. Weston's book has not previously been readily accessible to the average alcoholic. Furthermore, the writing is so clear, concise—yes, and entertaining—that it is easily understood. Indeed, Mr. Weston is not above pulling jokes on himself and exposing his own rationalizations and excuses for drinking. The alcoholic instantly recognizes his kinship and can hardly take offense.

The rehabilitation of the alcoholic embraces three fields, says our author: spiritual, physical, and psychologic. The spiritual is covered by Alcoholics Anonymous, perhaps too well, as it often engenders guilt feelings in a man already overburdened with them. Better to proffer a few psychologic insights, to promote understanding, and to show how the road to recovery is attainable.

There are many practical souls in the folds of A.A. who "slip" time after time, because the spiritual cure does not work. For them, a kind of disease cannot be cured by a kind of religion. They crave knowledge and wish to understand themselves. In this department, Mr. Weston excels. He blasts the concept that one must "hit bottom," become an utter slave to alcohol, before salvage can be begun. Early symptoms *can* be recognized and drinking *can* be stopped before further damage is done, but stopped absolutely, and the reasons are given.

Mr. Weston gives credit to many other sources from which he has drawn, but there is much evidence of original thinking. If the present book is successful, he says, he may go back and thoroughly examine the theories of Freud, Jung, Adler, and others, from the standpoint of alcoholism. It is from this direction that we would especially welcome more from Mr. Weston.

THEODORE A. ANDERSON, M.D.

Handbook of Obstetrics & Gynecology. Ralph C. Benson, M.D. Los Altos, California, Lange Medical Publications, 1964. Pp. 656, illustrated. ($5.00)

Long past due, this handbook will take an outstanding place on the library shelf along with the other famous and popular Lange handbooks. I am sure that this lucidly written manual with its enormous stock of usable information will be in the hands of the obstetrician and gynecologist just as frequently as one might expect it to be used by the general practitioner. Even the insides of the covers are crammed with such valuable information as obstetrical tables, tables of conversion or equivalent, and normal values for blood, serum, and plasma chemistry.

The illustrations by Laurel V. Gilliland, though all in black and white, are for the most part refreshingly new and original, beautifully done, and highly instructive.

ANTHONY F. PALMERI, M.D.

Respiratory Function in Disease. David V. Bates, M.D. and Ronald V. Christie, M.D. Philadelphia, 1964, Saunders. Pp. 566, illustrated. ($15.50)

In this text, the authors apply present knowledge of pulmonary physiology to a variety of lung diseases and disorders. The clinical, physiologic, pathologic, and radiologic findings of many conditions are coordinated. The subject is difficult and technical—at least it is to those of us who studied basic physiology thirty years ago. This emphasizes the tremendous advances that have been made in the field over the past quarter of a century.

The introductory chapters include a valuable glossary and a review of the methods for determining pulmonary function. Changes in pulmonary function as a result of position, exercise, age, and altitude are outlined.

The major portion of the book describes individual disease entities of the lung. Disorders most commonly encountered (emphysema, chronic bronchitis, lung disease caused by physical and chemical agents, and the secondary effects of heart failure) are emphasized. Cases are presented to show why correlation of x-ray, pathologic, and physiologic data is important in diagnosis.

The paper, print, and reproductions of chest roentgenograms and photographs are excellent. I commend this book to all who wish to further their knowledge and appreciation of lung disease and to learn how to recognize, measure, and evaluate lung dysfunction.

IRVING OCHERET, M.D.

Common Bacterial Infections. Edwin J. Pulaski, Col., M.C., U.S. Army. Philadelphia, 1964, Saunders. Pp. 301, illustrated. ($8.50)

Dr. Pulaski has compiled a concise and readable volume. The dynamics of the host, micro-organism, antibiotic triad are presented. Chapters are also devoted to infections of specific regional areas. Included are two excellent chapters on infection in trauma and in burns.

Newer antibiotic combinations, such as tetracycline with cephalothalin in acute biliary tract infections, and the choice of drugs and their role in recurrent staphylococcic infections are presented. The discussion of tetanus prophylaxis and the place of hyperimmune human globulin in preventing tetanus is a current and timely section.

This book pre-empts the previous classic in the field of surgical bacteriology by the late Dr. Meleney. Dr.

Pulaski's work is of value and interest to all practitioners, but will probably be most appreciated by those who do surgery and the surgical specialties.

The role of hyperbaric therapy in anaerobic infections is not touched upon, and some of the newer synthetic penicillinase-resistant penicillins are only mentioned in passing. This should encourage Dr. Pulaski to prepare periodic revisions of a book that is the best work currently available in the field of bacterial infections. ROBERT J. RUBIN, M.D.

Principles of Public Health Administration. J. J. Hanlon, M.D. St. Louis, 1964, Mosby. Ed. 4. Pp. 719. ($11.50).

For 15 years, Dr. Hanlon's *Principles of Public Health Administration* has been a standard text. And it is easy to see why. The book is written in a literate, readable, and compact style. It sees medicine as a social science. It offers the reader a serious and thought-provoking philosophic background to public health. Its orientation is medical and human rather than statistical and administrative. Administrative considerations are not neglected, since there are chapters on the financing, staffing, governmental, statistical, and legal aspects of public health programs. In addition to a coverage of communicable diseases—the traditional weft of public health—the text reviews problems in mental health, accident proneness, dentistry, maternal health, health education, addictions, public health nursing, and social service. A concise historical background enriches this valuable basic text.

HENRY A. DAVIDSON, M.D.

A Doctor Discusses Pregnancy. By William G. Birch, M.D. Chicago, 1963, Budlong Press Company. Pp. 114. ($1.50)

This compact paperback is for the pregnant patient. The text is clearly written, easily read, and informative. It will benefit not only the patient but the doctor, in eliminating many of the routine questions and phone calls. This book tersely explains the whys, whats, and whens of common physiologic and pathologic complaints.

The table of contents spans the entire course of pregnancy obviating any need for a glossary or index. It is a useful, informative, inexpensive, book as good as any on the market. ROBERT V. DORIAN, M.D.

Handbook of Heart Terms. Prepared by the U.S. Department of Health, Education and Welfare Bethesda, Maryland, 1964. Pp. 66. (30¢ each or $22.50 a hundred)

This modestly priced paperback was prepared by the National Heart Institute. In non-technical terms, it clarifies and defines the phrases used in cardiology and related fields. It will help professional people and the lay public to a better understanding of heart terms and should facilitate communication in this field. The material was prepared after a sample survey of science writers, and other groups of potential users indicated a need for such a booklet. Cardiologists and general practitioners will find it useful in interpreting technical concepts to laymen. Members of other professions dealing with heart disease will use it as a reference.

The manuscript received extensive review by many scientists, physicians, and writers during its preparation, and their suggestions have been incorporated into the booklet.

Copies are available from the Government Printing Office, Washington 25, D.C., at 30¢ per copy or $22.50 per 100. Single copies will be sent to physicians who write to the Information Center, National Heart Institute, Bethesda, Maryland 20014. Any cardiologist, family doctor, pediatrician or internist will find this a useful lubricant for communication with patients' families. ULYSSES S. FRANK, M.D.

BOOKS RECEIVED

Medical books are being released faster than this JOURNAL *can publish reviews. That our readers may be kept informed, we will hereafter release periodically a list of new books brought to our attention. Formal full-length reviews will be published as space becomes available. We still have some reviews of 1964 books not yet published and are releasing these reviews as rapidly as we can.*

Control of Glycogen Metabolism. Consulting Editor: W. J. Whelan, Ph.D.; Editor for Ciba Foundation: Margaret P. Cameron, M.A. Boston, 1964, Little, Brown and Co. Pp. 434 with illustrations. ($12.50). A record of a symposium on the subject, held in London in July 1963. Essentially for physiologists.

Principles and Methods of Physical Diagnosis. H. U. Hopkins, M.D. Saunders, 1965, Philadelphia. Pp. 503 with 332 illustrations. A thoroughly new and up-to-date edition of Simon Leopold's classical and useful handbook of physical diagnosis.

Clinical Tropical Medicine. Oscar Felsenfeld, M.D. St. Louis, 1965, Mosby. Pp. 378 with 40 illustrations. ($9.85). In this jet-travel age, every M.D. needs some knowledge of tropical medicine—a field compactly outlined in this book.

Physiology of the Eye. F. H. Adler, M.D. St. Louis, 1965, Mosby. ($18.75). Pp. 889 with 436 illustrations. A fourth edition of this encyclopedica treatise on the clinical applications of ophthalmic physiology.

Cellular Biology of Myxovirus Infections. Edited by G. E. W. Wolstenholme, M.A., M.D. Boston, 1965, Little, Brown, and Company. Pp. 368, with 85 illustrations. ($12.00). An attempt to clarify the incidences of the myxovirus.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

SEPTEMBER, 1965 • VOL. XXXVIII, NO. 7

THE BACTERIOLOGY AND CHEMOTHERAPY OF CHRONIC BRONCHITIS

Drug treatment of chronic bronchitis should not necessarily be delayed until bacteriological reports are obtained. The most important of the microorganisms in this condition is Hemophilus influenzae. In long-term chemotherapy, the tetracyclines are the drugs of choice.

Logical chemotherapy must be based on sound bacteriological principles, but this does not necessarily mean that the bacteriologist must always be consulted before a drug is given. In some syndromes the probability that a particular microorganism is causative is so high that "blind" chemotherapy is permissible. Chronic bronchitis belongs to this category.

The prevalence of *H. influenzae* in patients with purulent sputum seems to remain substantially constant from year to year. In contrast, the prevalence of the pneumococcus varies widely in different years and individual isolation rates have little meaning. Further, it seems that the prevalence of pneumococci in sputum cultures does not provide a reliable guide to the true occurrence of the organism in the lung, and it has been demonstrated that pneumococci are often found in sputum, probably as a consequence of contamination from the throat. The true role of the pneumococcus in chronic bronchitis is not easy to assess but there is no doubt that its main importance concerns exacerbations. Chronic pneumococcal infection of the bronchi without coincident *H. influenzae* is common, and when antibiotics eliminate pneumococci, pus does not always disappear.

The bacteriological principles upon which chemotherapy should be based may be summarized as follows: In patients without acute exacerbation but with purulent sputum, *H. influenzae* is the outstanding pathogen and the pneumococcus is probably of minor importance; in acute exacerbations without pneumonia, the pneumococcus assumes greater importance although its prevalence is variable from year to year; if pneumonia complicates bronchitis, there is the possibility of staphylococcal infection although the pneumococcus is the most common organism; there is no clear evidence that organisms other than *H. influenzae* and the pneumococcus are pathogenic in bronchial infections.

Therefore, the chemotherapy of patients without pneumonia should be directed against *H. influenzae* and pneumococci. Fortunately, neither organism readily develops resistance to antibiotics in common use and thus routine sensitivity tests are unnecessary. However, other problems of chemotherapy must be considered.

Selecting Chemotherapy

Patients whose sputum is always mucoid or contains only eosinophil "pus" derive no benefit from chemotherapy whatever organisms are present. Therefore, it is necessary to be sure that true pus is present before chemotherapy is prescribed. Eosinophil "pus" is most common in patients with an allergic history.

J. Robert May, M.D., *British Journal of Diseases of the Chest*, April, 1965.

The greatest problem is the recurrence of infection when therapy is stopped. Such recurrences are usually associated with *H. influenzae*. The rapidity of recurrence suggests relapse of the original infection, but could mean a reinfection with a different strain.

The tetracycline group of drugs have come to be considered the drugs of choice for long-term chemotherapy since they can be given by mouth and are relatively free of side effects.

In the last decade several clinical trials have been carried out in an attempt to assess the precise value of chemotherapy. A detailed analysis of all the reports seems unnecessary since a number of general conclusions are apparent. Perhaps the most important is the attention that these trials have drawn to the care needed in interpreting results.

Assessing Progress

The objective criteria most commonly used for assessment of progress were sputum purulence and number and duration of exacerbations. But sputum purulence and number of acute exacerbations are not necessarily linked. A patient can recover clinically from an exacerbation sufficiently to return to work although his sputum is still purulent. Likewise, a patient may have lost his pus but be unable to return to work because of increased dyspnea. In general, loss of pus will indicate control of *H. influenzae* — the basic chronic infection. Clinical improvement in an exacerbation may well be due to suppression of a pneumococcus and, since the prevalence of this organism varies from year to year, a given antibiotic may not be equally effective in different trials.

Both intermittent and continuous chemotherapy are valuable forms of treatment if the patients are properly selected. The patient who has occasional purulent sputum but is "mucoid" for most of the time is a candidate for intermittent therapy, while the one whose sputum is purulent throughout the winter *must* be given continuous therapy.

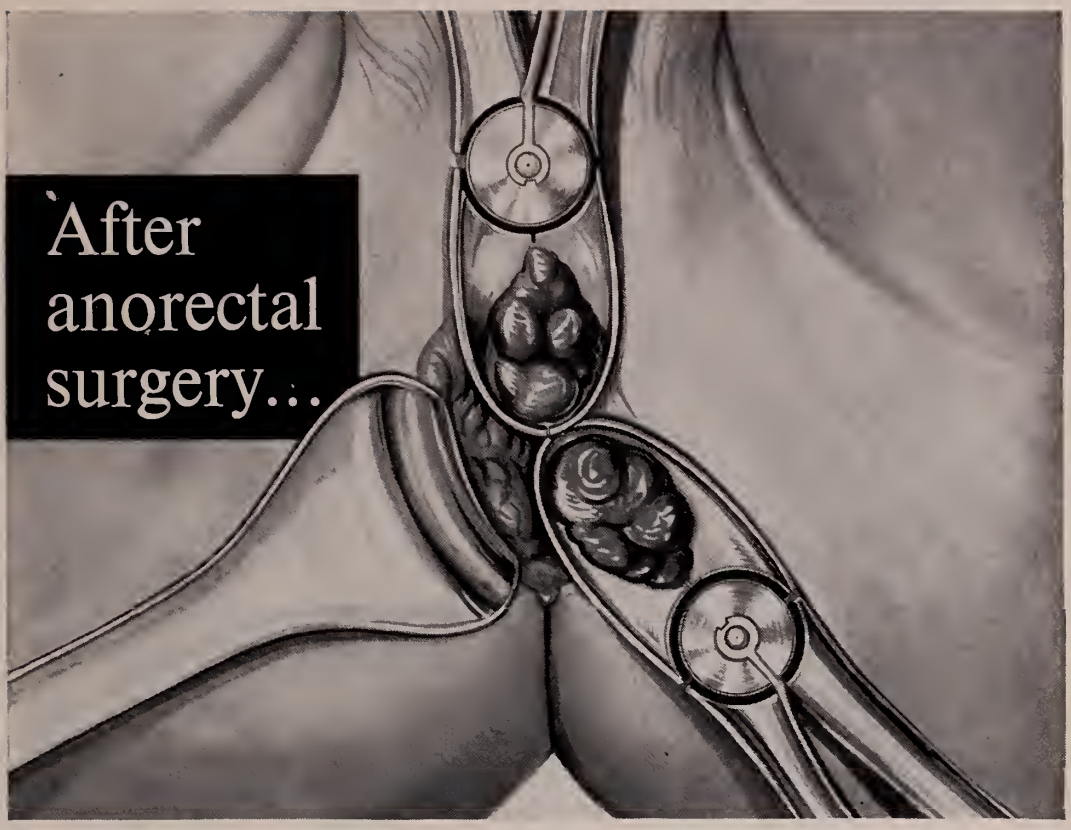
Other Drugs

As regards drugs other than the tetracyclines, trials have covered phenoxy-methyl-penicillin, erythromycin, oleandomycin, novobiocin, sulphamethoxypyridazine, and "sulphatriad." Taking account of all the factors, there can be no doubt that tetracycline itself is usually preferred. Sometimes a combination of tetracycline with another antibiotic will succeed where tetracycline alone fails. Tetracycline in concentrations that can be attained in tissues acts by bacteriostasis.

Bactericidal therapy is theoretically possible with ampicillin. It has been found that the highest concentrations appear in the sputum when pus is present, and as the inflammation subsides the level falls until it can often no longer be measured. The crucial factor in treatment is that the infecting organism should be killed before the sputum concentration falls to the ineffective level. As this fall may occur in only a day or so, it is essential that treatment should be directed toward attaining very high sputum levels in the first few hours. It is clear that the sputum as well as the tissue must be sterilized if relapse is to be prevented. Failure of the antibiotic to penetrate into mucoid bronchial secretions may explain the failure of bacteriostatic therapy to give more lasting benefit. If the microorganisms in the secretions are inaccessible to the antibiotic and there are no phagocytes present, there is no reason why they should not remain viable indefinitely and able to cause a fresh infection as soon as the bronchial tissue is freed from protective antibiotic.

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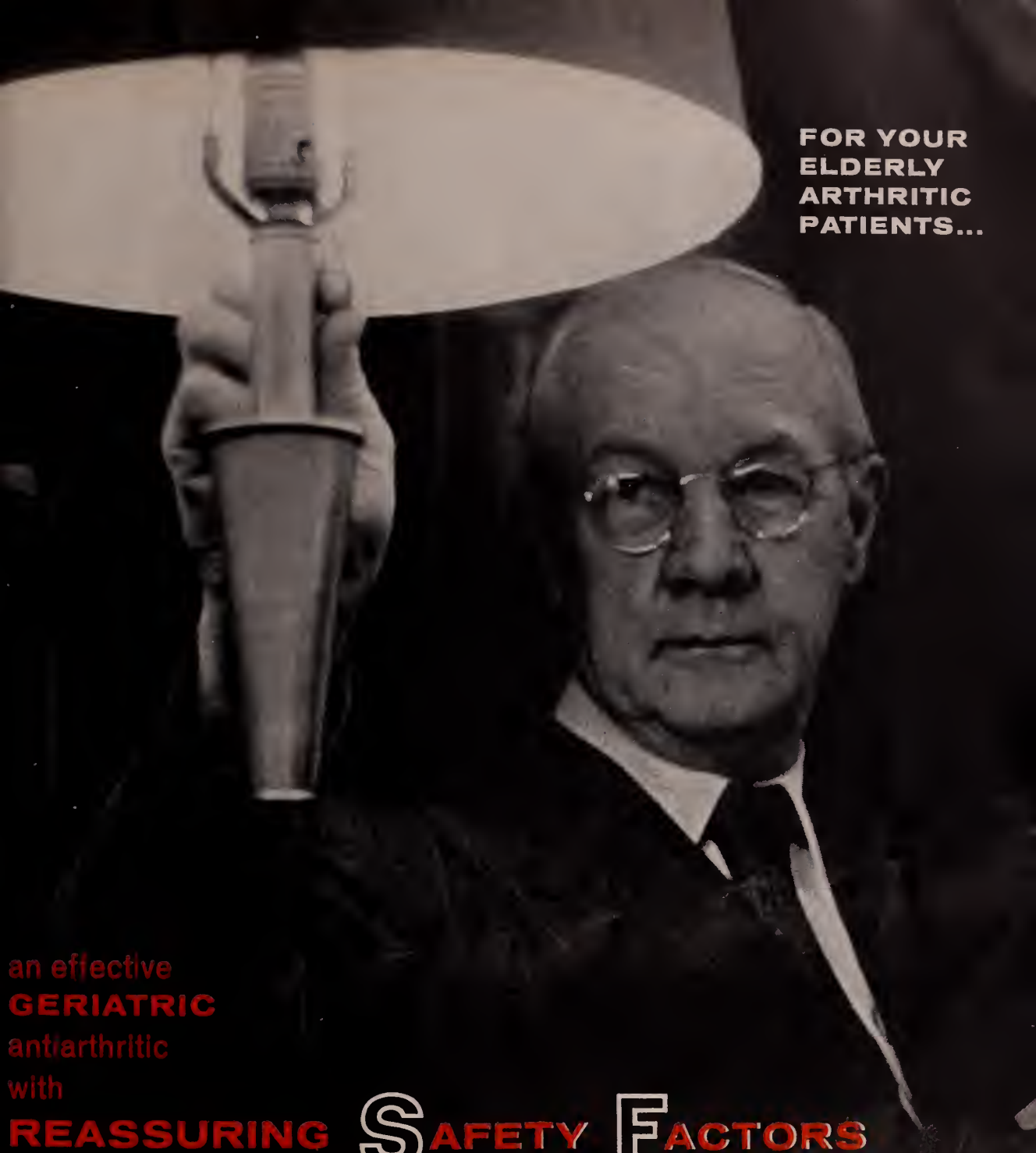
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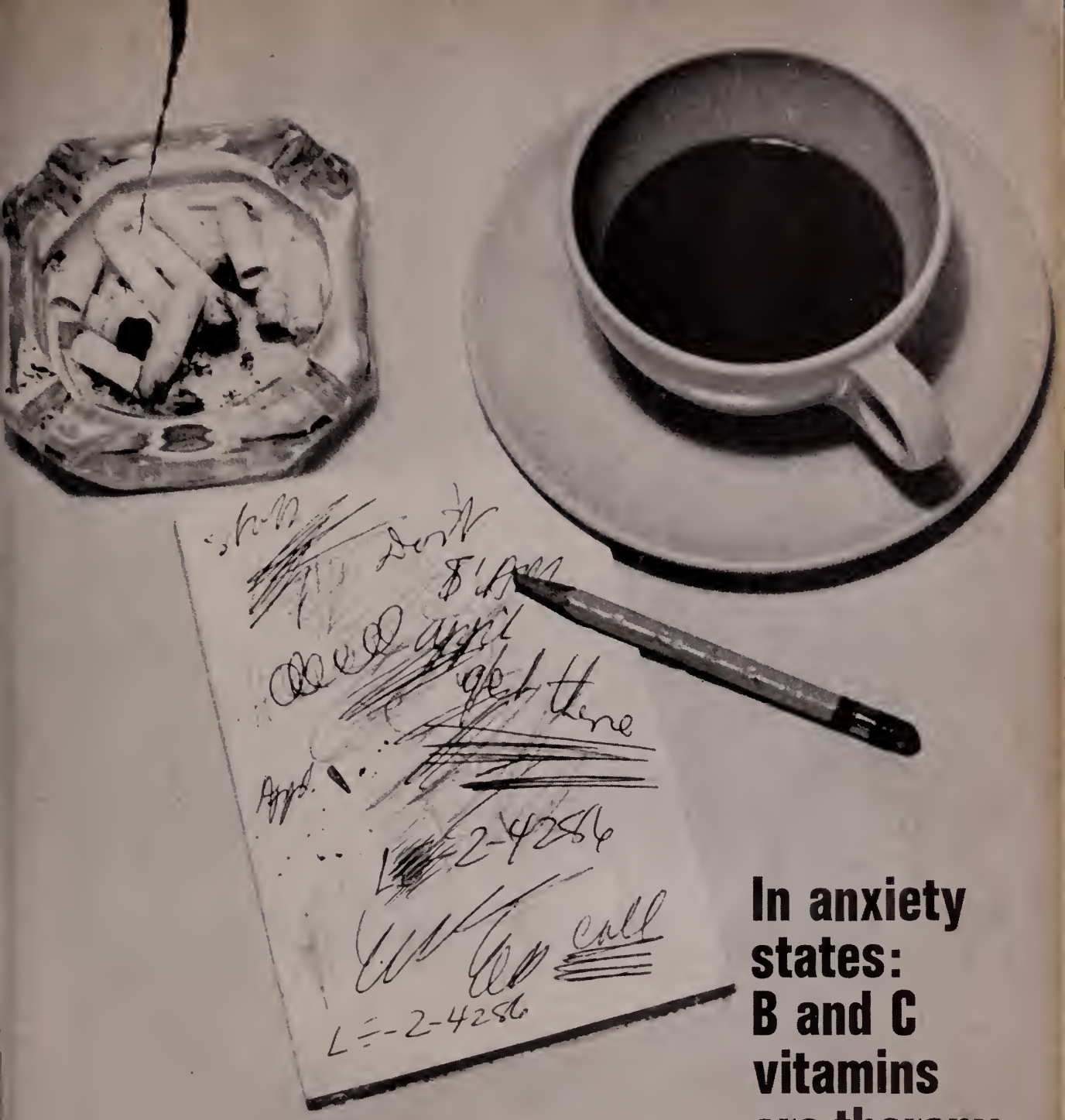
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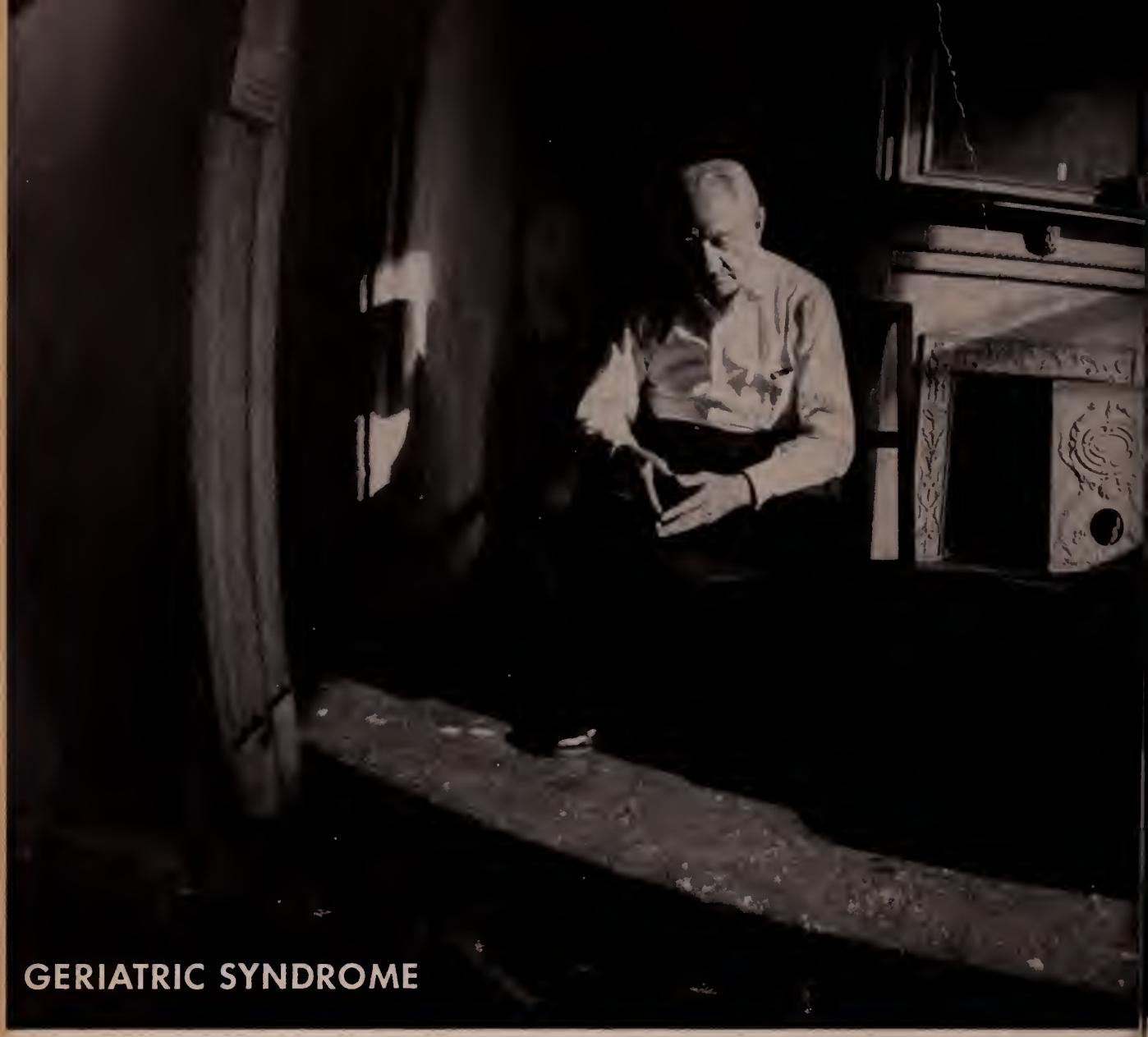
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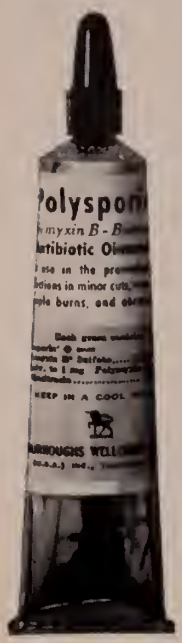
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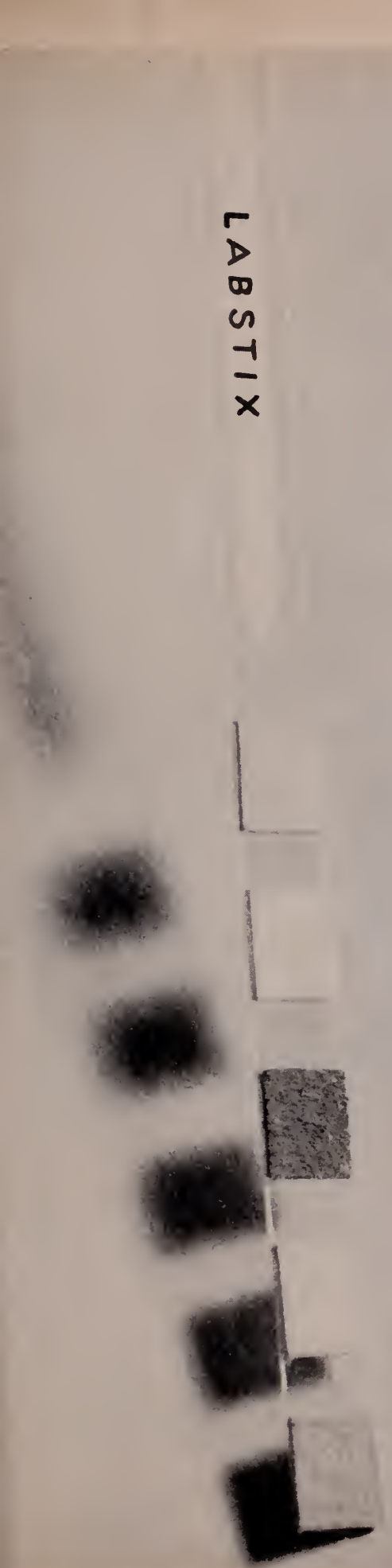
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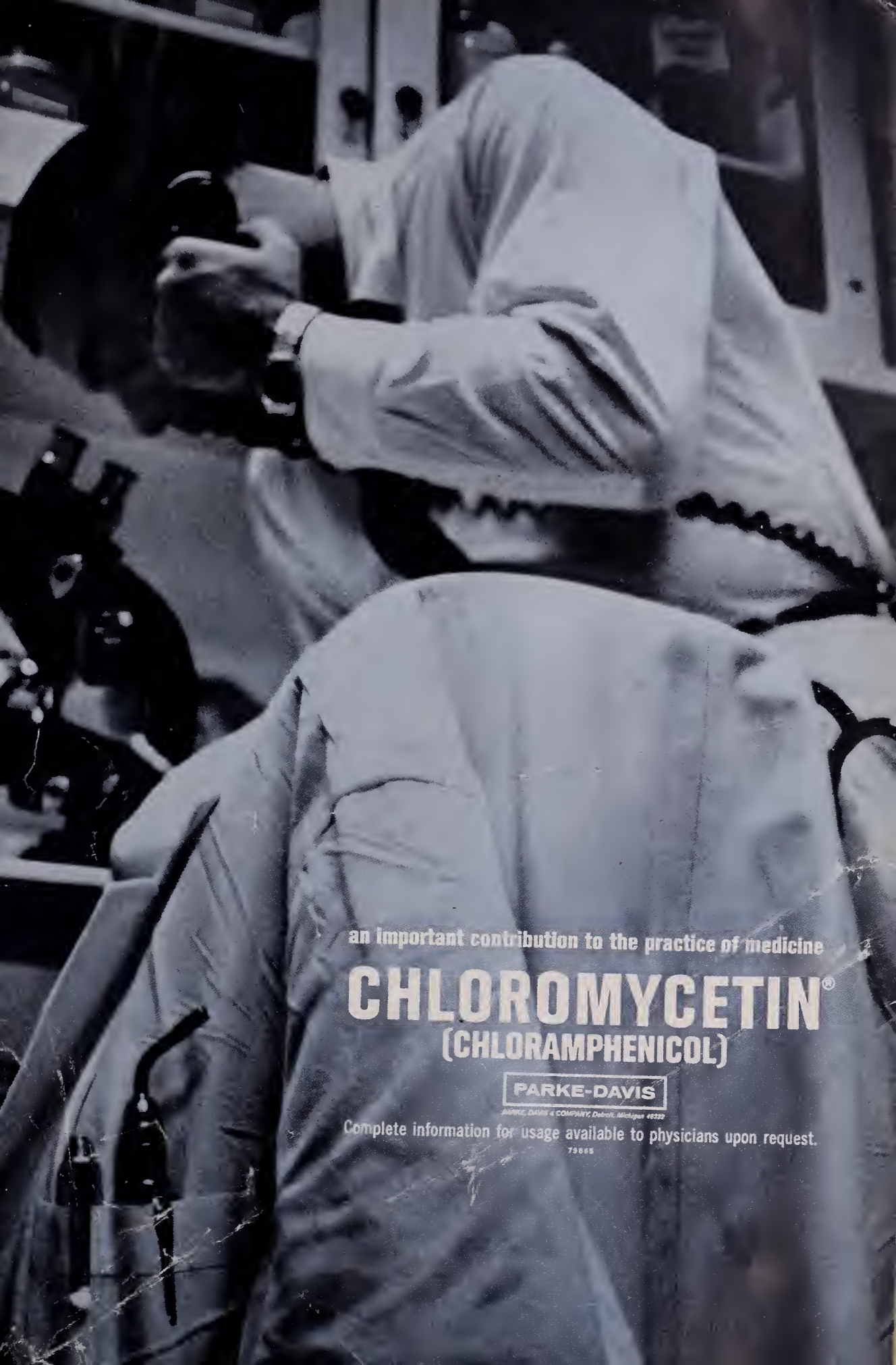
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Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

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Initially, give 400 mg. daily (one tablet or capsule q.i.d.), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. To minimize gastric distress, Butazolidin alka capsules may be the preferred form.

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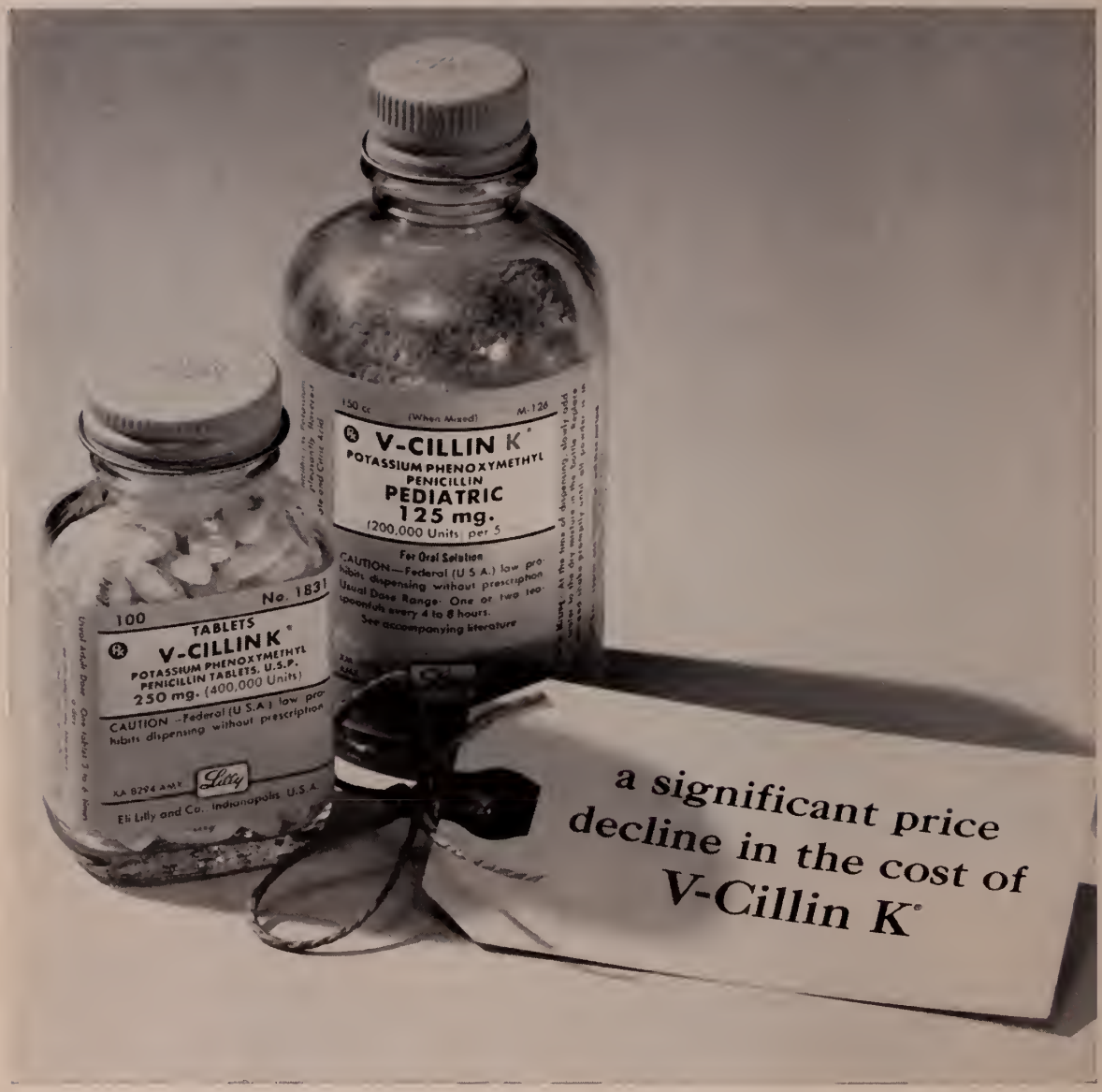
Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

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Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

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EDITORIALS

Support Without Anxiety?

Following the success of tuberculosis and poliomyelitis campaigns, many other diseases have been sponsored by voluntary health organizations. In his book *The Gentle Legions* (Doubleday 1961), Richard Carter enumerates organizations for heart disease, cancer, muscular dystrophy, allergy, deafness, diabetes, leprosy, venereal disease, arthritis, leukemia, myasthenia, alcoholism, cystic fibrosis, hemophilia, nephrosis, dystrophies, parkinsonism, cerebral palsy, and facial disfigurement. Psychiatric organizations have not been nearly as successful in holding public interest as have been the sponsors of many diseases of lesser prevalence. Mr. Carter complains that mental health organizations "have not displayed stomach for leadership as vigorous as that of the reform movements of the early century." The local mental health associations, suggests Mr. Carter, "are in competition with and essentially indistinguishable from Abby Van Buren, Norman Vincent Peale, the local parson, and other well-intended dispensers of useful advice."

Many observers have commented on the apparent "gentleness" of the approach used by mental health organizations. What Mr. Carter and other critics fail to understand, however, is that this is one crusade that just can't afford to generate anxiety. The commonest way of getting emotional and financial support is to scare people into helping—usually by implying that without the organization, they or their family may fall prey to the disease. Most of us think that this is bad mental hygiene, and we can hardly use it to develop an organization devoted to good mental hygiene. Presumably, though, there should be some way of arousing popular support without provoking overwhelming anxiety.

Playing With Hallucinogens

Just as some have converted hypnosis from a medical technic into a public entertainment, so there are those who would see the hallucinogens as a kind of harmless game. We now have a wide spectrum of such drugs—morning-glory seeds (curiously named!), LSD, marijuana, psilocybin, peyote, and several others. The theory is that these drugs expand the consciousness; allow you to see other, inner, and outer worlds; remove the envelope of every-day experience from your judgment (thus allowing your mind to soar into the never-never); and offer a short, safe, and charmingly dizzy ride to paradise and back. It would seem clear that the persons with the strongest wish to escape reality would be those who find reality unattractive. In simple language, those who can't adjust to present reality are "maladjusted." These and the basically unstable seem especially prone to take a ride on the magic carpet of the hallucinogens. Some of its promoters assure us that this is safer than riding in a speeding automobile which, when you come to think of it, is not much of a recommendation. It has also been suggested that creativity is enhanced by taking these hallucinogens. Here is what is meant by "pipe dreams": but pipe dreams are notorious for their lack of substance.

Dana Farnsworth,* as health director at Harvard, has made serious studies of the effects of these psychotomimetic drugs. He tells us that comments from some of these drug takers have included the following:

—I kept a journal while on the drugs. Later I read it and it was horrible. People were tearing each other apart.

—I had a horror-show after taking the morning-glory seeds. I felt my brain would blow up. I felt I was losing my mind. I felt I was going to die but I couldn't communicate it to anyone. I tried to tell my brother but couldn't make him understand.

—(On experiences with LSD-25) I had a compulsive urge to do violence to my children . . . nor do I know myself to this day how great the gap was between the violent thoughts in my mind and their possible execution.

—(A research worker who took a number of psychoactive drugs, including tranquillizers, sedatives, alcohol,

* Farnsworth, Dana L.: Journal of the American Medical Association, 185:164 (September 14, 1963)

and LSD-25) Man continues his search for the jinni that will come out of a bottle and do his work for him. I did not find it. Each of the drugs I took, in one way or another, impaired what I conceive to be optimal functioning. None of them gave me any substantial sense of betterment.

"In our files," continues Dr. Farnsworth, "is the report of a student who took one of the drugs and spent a whole day living the nightmare that he was only 6 inches tall; during this period he was helpless and had to be cared for by friends. In another case two friends took the drug together: one sobbed uncontrollably for 3 hours. As a consequence of a single ingestion of LSD-25, Asher spent several days in bed, babbling or crying; for some weeks afterwards he was subject to horrid, involuntary hallucinations; and for months was dependent on barbiturates for rest at night.

"In our experience, several students have had to be hospitalized for long periods following the ingestion of small amounts. We have no basis for identifying persons for whom the drugs are 'safe' and persons whom the drugs will take into a prolonged, perhaps permanent, psychois. We observe that, whereas rational and prudent individuals have a tendency to stay clear of the drug experience, neurotic and unstable people are attracted to it."

One of the interesting aspects of this new fashion is the high proportion of nonmedical workers in the field. Indeed, many of the experimenters boast of their rejection of what they call "the medical model of experimentation." The rationale is as follows. Typically, a physician administers a drug to a subject, but not to himself, so he can objectively measure results. This is the "medical model". With psychotomimetic drugs, however, the theory is that you can't appreciate the effect unless you experience it. Therefore the best observers would be users. (Apply this to a study of heroin addiction and see where you get!)

Certainly the subject is interesting, might be important, and is surely worth investigating. But no one should be permitted to tamper with human metabolism, human biochemistry, or the human mind, for that matter, without solid medical orientation. And no one should be made a guinea pig for these experiments without knowledgeable agreement to undertake the risks and a promise of meticulous medical observation and control during the toxic state.

Here is one flight no one should take without fastening his seat belt.

Diabetes Detection Week

November 14—November 20, 1965

Each year in November, the American Diabetes Association and its component societies promote a campaign for the education of the population at large and the instruction of the medical community. The aim is to ferret out the early unrecognized diabetic. Most people with controlled diabetes have an excellent chance of leading long and useful lives. Diabetes, however, cannot be controlled until it has been diagnosed. The earlier it is diagnosed, the more favorable the prognosis. This is a serious consideration for over one and a half million people in the United States who have diabetes and do not know it. This is a challenge confronting the physician of today.

Purpose of the Diabetes Detection Drive is to find as many as possible of those unsuspecting diabetics and to see that they get proper medical attention. This can be done only by creating widespread public knowledge of diabetes and awareness of its dangers. The awesome complications of diabetes can be delayed by proper management, and the patient can then lead a more useful life and not become a burden to his family and his community.

This yearly drive is only a reminder that the process of diabetes detection must be a year-round job. Only in this way can the uphill fight be won. This is the doctor's job: yours and ours. Let us continue in a position of leadership!

ORIGINAL ARTICLES

Physicians see the proposed community mental health centers as great boons in the immediate and short-term care of the emotionally ill. But where is the money coming from?

Financing The New Mental Health Services*

Edward A. Mooney, LL.B., M.S.
Princeton

The Community Mental Health Centers Act of 1963 was expected to provide for staffing of the proposed centers. However, funds were authorized for construction only. It thus appears that the burden of staffing and operating these services will fall on individuals and on local communities. Although communities may be expected to provide some subsidies to assist in the operation of Community Mental Health Centers, it appears obvious that most of the financial burden will fall upon the patients. Their ability to pay will in turn, rest largely on the coverage provided by pre-payment and other insurance programs. Apparently President Kennedy, in his special message on Mental Illness and Mental Retardation, recognized this when he said, "The success of the pattern of local and private financing will depend in large part upon the development of appropriate arrangements for health insurance, particularly in the private sector of the economy."[1]

To determine what the patient or pre-payment insurance plans are expected to pay for, we must examine the scope of the programs. It is our understanding that a center will be concerned with the total medical needs of the individual and with the needs of varying types of psychiatric problems. These cover a broad spectrum of services and may vary from that of a child with a learning problem, to an adolescent with a behavior problem, to an individual with an emotional problem, to a major mental illness such as psychosis, brain damage, and mental retardation. The Community Mental Health Center will arrange for psychiatric treatment, psychological and social work services, day care, night care, admission to psychiatric units of general hospitals or to a county or state hospital, after-care services, foster home placements, rehabilitation and job placement services.[1] Emergency services are expected to be immediately available on a 24-hour-a-day, seven-days-a-week basis, so that emphasis will be placed on early referral and intensive short-term therapy. Apparently, as Community Mental Health Centers develop, the range of services will differ from the traditional in-patient and out-patient care.

What does this mean to pre-payment and other health insurance carriers? Today, some 80 percent of the population is covered by some form of health insurance for in-patients. Back in 1955, as many as 40 Blue Cross Plans had no significant provisions for in-patient psychiatric coverage. This changed so radically that, by 1963, 61 Blue Cross Plans had included in-patient benefits for emotional and mental conditions under their most comprehensive group certificates; and 68 provided some kind of benefits under the most comprehensive group certificates.[1] The Hospital Service Plan of New Jersey has for many years

* Read May 18, 1965 at Atlantic City at the annual meeting of The Medical Society of New Jersey. Mr. Mooney is the Executive Director of our State's Health Facilities Planning Council.

provided at least 20 days of hospital care for psychiatric services. Commercial insurance companies have covered "nervous and mental conditions" as part of their basic hospital insurance written for groups, although this coverage may not apply to individual contracts.[1]

Out-patient coverage for the mentally ill suffers by comparison. Usually out-patient coverage is available only under an extended benefit or major medical type of certificate. In most cases, the pre-payment organizations protect themselves by providing for an initial deductible and co-insurance feature, which many people in the mental health field believe to be a deterent to early treatment.[1]

More data are becoming available, however, and some improvement in experience is apparent. Under the Federal Employees Health Benefits Program, both Blue Cross and Blue Shield offer benefits for out-patient care. Their in-patient hospital days are the same for mental disorders as for other disorders: 120 days under the high option and 30 days under the low option. It is reported[1] that in this program (which covers six million federal government employees) there were only 2.1 admissions per thousand, an average length of stay of 11 days and an average of 23.1 patient days per thousand members.

Group Health Insurance Incorporated (New York) carried out a 30-month research project under a federal grant. They found that the total utilization rate of short-term psychiatric patients, among 76,000 subscribers, was 12 per thousand for the thirty months. The annual rate was 6 per thousand. The study concluded that there appeared to be little danger that the cost of insuring for the services covered by the project would be prohibitive, if spread over an average cross section of the population.[1]

The General Electric Company's health insurance plan covers about 662,000 workers and dependents. It provides benefits for emotional and mental conditions as well as other disorders. For out-patient psychiatric care, it reimburses the patient for 50 per cent of his expenses. General Electric is reported to have found that psychiatric cases accounted for only 2.6 per cent of all its experience and constituted only 5.4 per cent of the benefits available under the plan.[1] Also there is a report[3] on the psychiatric care insurance program underwritten by the Tennessee Hospital Service Association. Here, major medical coverage augmented a typical Blue Cross-Blue Shield contract for basic benefits which did not cover psychiatric services. They provided coverage for mental illness the same as for physical illness, with the insuror paying 80 per cent of the charges after an annual deductible was satisfied. The deductible amount, $200 when the coverage was started, was later dropped to $100; with $50 applicable when another family member had satisfied an annual deductible in the same year.

The unique aspect of the program was the absence of maximums in terms of days, visits, and the almost complete absence of ceilings on prices per unit of care. The one exception to the absence of price ceilings was an initial maximum hospital room and board charge of $15.00, later raised to $20.00, toward which the insuror would pay. However, this maximum was sufficient to cover 97 per cent of hospital charges. The services of psychologists were excluded.

Their experience indicated that, although dollar claims for psychiatric care *more than doubled* over the five years of the program, payments nevertheless tended to remain *in the same proportion,* approximately 20 per cent of the total major medical insurance payment, thereby keeping a constant cost relationship with the whole program. Payments for psychiatric benefit periods were almost double the average major medical payment, indicating that although it was expensive per claimant, nevertheless *there were few enough claimants so that total psychiatric care payments remained a minor part of the total major medical expenditures.*

The study concluded that pre-payment of the cost of psychiatric care on a broad and relatively unrestricted basis was feasible. It suggested that when claims costs are spread over the total insured population, in all kinds of hospitals, actual charges for psychiatric care

were less than $2.50 per person-year, and were even less than $2.50 when the deductible and co-insurance amounts are considered. It was carefully pointed out that the $2.50 per person-year equates with the middle years between 1956 and 1960. Accordingly, in applying any rate making for 1965 or subsequent years, it will be necessary to adjust them upwards to take into consideration rising medical costs. The study concluded with the statement that preventive and community psychiatric care can be fully implemented only from broadly financed bases, such as pre-paid group psychiatric insurance.

The experience of insurance companies in covering the cost of care for mental illness under major medical expense, although limited, tends to support the findings of both Group Health Insurance and General Electric.

Summarizing experience in the insurance industry generally, Follman[4] has reported that the proportion of all cases involving mental illness was about 2.5 per cent; that the proportion of all benefits being paid for the treatment of mental illness is some 5 to 7 per cent, with some 35 to 40 per cent being for hospitalized cases and the remainder being for non-hospitalized cases; that in many cases, more than one member of the family was under treatment simultaneously; that a sizable proportion of patients (some 15 per cent) use three or four different doctors in the course of treatment; that experience can differ markedly with the occupation of the group insured, with their social, economic, and cultural characteristics and with geographic areas.

An indication of the extent of benefits which professional personnel in the mental health field would like to have covered might be helpful. This perhaps can be best understood by considering the recommendations of a Task Force established within the National Institute of Mental Health. After meetings with the major insurance carriers, the Task Force suggested concepts[5] for insuring against mental illness in anticipation that they might lead to the development of broader coverage. Briefly, they were as follows:

1. Emphasis should be placed on early referral and short-term intensive therapy. It was suggested that, in the category of out-patient benefits, low deductable features be offered to encourage early referral and low co-insurance. It was further suggested that the cost coverage might be 100 per cent for the first few visits, with progressively decreasing percentage costs for subsequent visits up to a stated limitation.

2. In-patient hospital benefits should be increased and partial hospitalization (day and night care) should be included in in-hospital benefits for mental illness; should be as complete as for physical illness and that expenses incurred within day and night hospital programs should be covered even though a patient's so-called daily length of stay might be less than 18 hours. The Task Force reported that day care programs could be less expensive than 24 hour treatment; that they decrease the tendency towards dependence and retain the patients ties with family and community.

3. Increased recognition should be given to all professional skills essential to treatment. Besides benefits for the services of psychiatrists or other M.D.'s, they urged that the services of a clinical psychologist, psychiatric social worker, and psychiatric nurse also be covered if they functioned under the supervision, or at the request, of a physician.

4. Insurance should not favor a particular type of treatment. This suggestion was made to encourage whatever treatment would be best suited to a patient's needs.

5. Prescribed drugs should be covered for ambulatory as well as for hospitalized patients. It was pointed out that drugs may be the very factor keeping some patients ambulatory.

Despite the desire on the part of mental health authorities for broader coverage, the experience to date has generally been limited to specific groups. This has led the insurance industry to offer suggestions for further consideration in order to better understand the problem so that it can plan to meet the need. The suggestions[6] are:

1. That psychiatry establish patterns of care that are acceptable to, understood by, and demanded by the public; and that the cost of such care be reasonably predictable.

2. That there be developed usable data on the incidence, cost, and care for mental illness. However, before comparable data can be gathered, there must be an agreement: *first,* on what constitutes a case of a specified type of mental disorder; *second,* there must be developed standardized case finding methods for detecting cases and a standardized method for their classification; *third,* it will be necessary to devise methods for measuring the duration of illness and for characterizing the degree of psychiatric disability; *fourth,* there must be an understanding that insurance against mental illness cannot proceed beyond a certain point until there is a greater public demand; *fifth,* there must be a greater priority for mental illness coverage in the purchase of group insurance, for man-

agement and labor will play an important role in determining the pattern of future mental health insurance coverage. *Finally,* the public must recognize the need for covering mental health illnesses and must be prepared to devote more funds to such added protection.

In fairness to government, individuals, prepayment plans, and other sources from which payment is anticipated, it must be admitted that the complex variety of services to be offered by Community Mental Health Centers does not readily lend themselves to clear precise definitions. All of the sources of financial support for such services will want to know the number of *dollars* which will have to be expended to provide benefits. More specific cost figures must be developed. To do this, it may be necessary that payment for benefits within Community Mental Health Centers be developed on a step by step basis. This does not mean that progress must be so cautious that nothing constructive can be accomplished. However, it does seem that more "pilot" programs will have to be carried out to gain experience in the operation of Community Mental Health Services, so that the public, government, the insurance carriers and Blue Cross-Blue Shield will be afforded the necessary foundations on which to build their own programs.

When we think of patient demand, it is always desirable that we go back to the community to determine what the man on the street really thinks he needs in terms of services. The New York City Community Mental Health Board was concerned about the views of the public with reference to community psychiatric services and decided to take appropriate action. It engaged Columbia University School of Public Health and Administrative Medicine to undertake a sociologic survey of the problem. Here are their findings:[7]

Most persons (94 per cent of them) believed that there should be a telephone information service available day and night to tell a caller where immediate help might be obtained for himself or someone else. Other services highly approved were: walk-in or trouble shooting clinics; emergency psychiatric service; psychiatric services in a general hospital; neighborhood after-care and rehabilitation services. Less unanimously demanded, but considered desirable, were the older mental hospitals, night hospitals, and day hospitals. The survey indicated that there was a need to increase the public's acceptance of community psychiatric services. Presumably, lack of community acceptance was related to the findings that nearly half of the public does not know that the psychiatrist is a doctor of medicine. Only a few of those contacted had any personal relationships with psychiatrists.

Labor and management will do whatever purchasing is done. If the demand is there, Blue Cross-Blue Shield and the insurance carriers or Government will provide the coverage. It is essential, therefore, to get experience to assure labor and management that the cost of these fringe benefits will be within a reasonable range, and will not be so excessive that they will create competitive disadvantages which may have an adverse effect upon both labor and management.

The achievement of comprehensive medical care is a major goal of the labor movement. The United Automobile Workers have expressed the philosophy that what is good for the community is good for its members.[8] The UAW has expressed support of mental health programs by providing for extensive psychiatric coverage for its members, effective September 1, 1966, through Blue Cross-Blue Shield. Although the details of these benefits have not been finalized, it is reported[9] that there will be particular emphasis on the functions of Community Mental Health Centers.

Labor is aware that the overwhelming numbers of persons who fill our mental hospitals come from the ranks of blue collar workers, who are suspicious of psychotherapy. They want something definite which they can understand, such as pills, drugs, and machines that cure quickly.[8] Labor leaders are inquisitive about personnel. Will they be available to offer the services? Will they be offered by travelling teams, through visiting clinics, through increasing relationships with general hospitals? These questions must be answered.

The principle of shared financing for the payment of psychiatric services will continue to grow. Before it can be clearly established that fees for service are supportable (on a broad scale through insurance coverage) it will be necessary to find ways of responding to the many questions asked by pre-payment agencies, labor, and the public generally. Presumably, these cannot be resolved in any speeded up program. Psychiatry does not lend itself to easily understood definitions, such as fractures, heart disease, or other medical diagnoses. This difficulty, however, can be resolved, although it places on the professional personnel in the field an obligation to provide essential answers to the pertinent questions being asked. It must be realized that the questions are asked in helpful pursuit of a satisfactory solution to the problem. They are not intended to avoid adequate coverage for psychiatric cases by insurors.

Conclusion

It appears that for an interim period, at least, the services provided by Community Mental Health Centers will be supported from several sources, such as Government, pre-payment plans, by individuals, and by public and private social welfare organizations. Gradually, as the demand increases (which should develop from greater awareness of the need), there should be an expansion of coverage by Blue Cross, Blue Shield, commercial insurance, and private plans. As a result, the availability of funds to individuals to pay for mental health services will increase, so that a greater share of the cost of operating such Centers should be assumed by the private sector of the economy, as suggested by President Kennedy.

Payment for mental health services is a complex matter, and the final answer to whether fee-for-service can be successfully combined with other methods of payment will depend on the extent of professional guidance, the types of services eventually developed under the Community Mental Health Center Program, the demand for those services, and a willingness on the part of the public to pay either directly or through adequate subscription rates to third party payors.

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Highway 206

Military Patients Under Civilian Care

Fort Jay (Governors Island) is scheduled to close by June 1966. The U.S. Army Hospital Fort Jay is starting to reduce its services and support of military personnel. From now on, all transactions concerning military patients hospitalized in civilian facilities presently handled by this hospital (to include billing for hospitalization and treatment) will be referred to U.S. Army Medical Detachment (1325), U.S. Naval Hospital St. Albans, Jamaica, Queens, New York, Telephone JA 6-1000 ext. 510 or 506.

A stroke must not be considered as rendering a patient fit only for custodial care. Much can be done if precise diagnosis can be formulated.

Diagnosis and Management of Cerebrovascular Disease*

Jerome G. Kaufman, M.D./Maplewood
Howard J. Frankel, M.D./Newark

Recent advances in the recognition, prevention and treatment of cerebrovascular disease have created great interest, not only for physicians but for other ancillary services as well.

At one time we spoke of "cerebrovascular accident" as an all inclusive term for all types of cases. Today, because of newer technics, we can often make a more accurate diagnosis. And it is important to try to arrive at an exact and precise diagnosis.

Cerebrovascular disease is the number three killer in the United States, claiming 200,000 lives yearly and accounting for eleven percent of our annual mortality.[1] It is estimated that today two million people in the United States are suffering from cerebrovascular disease. Many of those patients have had premonitory symptoms, such as transient ischemia or "small strokes," from which they recover quickly. These "small strokes" frequently herald the possibility of a major cerebral thrombosis in the future, and fifteen percent of these patients have a recurrent episode within two years.[2,3] Prophylactic therapy must always be considered following an attack of transient ischemia.

The cerebrovascular lesions (Group I in the table) are sometimes amenable to surgical therapy; e.g., transient ischemic attacks or saccular aneurysms. These conditions are indicated by an asterisk in the chart. The lesions may be completely reversible with proper therapy. The remainder of the conditions outlined in the table are usually managed medically; but medication indicated in some instances is *absolutely contraindicated* in others; e.g., the use of anticoagulants in cerebral hemorrhage.

Physical medicine and rehabilitation have made many advances emphasizing the importance of making every effort to bring patients successfully through the acute stages of "strokes." This can be done only following an accurate diagnosis.

Diagnosis

The discussion will now focus on cerebrovascular disease to the exclusion of the nonvascular entities previously mentioned and also attempt to appraise the battery of tests now available as to diagnostic significance, safety, and simplicity. A good *history* is still the road to correct diagnosis.

(a) Onset—a rapid and sudden onset points towards cerebral embolus or subarachnoid hemorrhage; a gradual onset (over several hours) suggests cerebral infarction or intra-

* Presented at Atlantic City, May 17, 1965, at the Annual Meeting of The Medical Society of New Jersey.

I. CEREBROVASCULAR DISEASE

A. Atherosclerotic-Ischemic
- *1. transient, intermittent cerebral ischemia
  - a. carotid
  - b. vertebral-basilar
- 2. thrombosis-in-evolution
- 3. completed stroke

B. Hemorrhagic
- 1. hypertensive-atherosclerotic
- *2. saccular aneurysm
- *3. arterio-venous maiformation
- 4. blood dyscrasia
- 5. anticoagulant overdosage
- *6. intracerebral hematoma

C. Embolic
- 1. thrombotic
  - a. cardiac arrhythmias
  - b. cardiac mural thrombus
  - c. paradoxical embolus
  - d. pulmonary venous thrombus
  - e. arterial thrombus
- 2. fat—traumatic
- 3. infectious-bacterial endocarditis
- 4. secondary to intraarterial procedures, i. e. catheterization or angiography

D. Non-Atherosclerotic
- 1. polyarteritis nodosa
- 2. systemic lupus erythematosus
- 3. miliary tuberculosis with arteritis
- 4. tertiary syphilis
- 5. other vasculitis

E. Cerebral Venous Thrombosis
- 1. post partum
- 2. severe dehydration
- 3. sudden weight loss

II. NON-VASCULAR

A. Brain Edema

B. Subdural Hematoma

C. Brain Tumor

D. Hypoglycemia

E. Uremia

F. Hypocalcemia

G. Hyponatremia

H. Toxic, i. e. Lead Barbiturate

I. Shock

J. Trauma

K. Infection, i.e. Brain Abcess Encephalitis

*A correctible lesion

In reviewing the diagnostic chart, note that several different conditions there listed can masquerade as "strokes"; yet they can be treated medically or surgically in an encouraging number of cases.

cerebral hemorrhage. A slowly progressive onset (spanning a few days) indicates a subdural hematoma.

(b) Course or evolution—a slow resolution occurs in some cases of cerebral infarction, while a progressively downhill course occurs often in cases of:

(1) cerebral hemorrhage
(2) subdural hematoma
(3) cerebral infarction with extensive brain edema

Another important historical aspect of cerebrovascular disease is consideration of episodes of transient cerebral ischemia. These are remitting and relapsing attacks, which antecede cerebral infarction. In fact, 50 percent of patients with transient ischemia develop cerebral infarcts.[2] These are usually due to thrombotic atherosclerotic disease of the cerebral vessels as they pass through the neck. In 60 to 80 percent of cerebral infarcts, there is a history of prior episodes of transient ischemia.[3] These attacks may be of carotid or vertebral-basilar artery origin. Carotid attacks are usually unilateral. Vertebral-basilar artery ones are bilateral, or the symptoms alternate from side to side. The contralateral signs of carotid involvement are:[4]

(a) weakness
(b) paralysis
(c) sensory disturbance
(d) aphasia, etc.

The ipsilateral signs are blindness in one eye (amaurosis fugax) and migraine-like headaches.[4] Among the symptoms of vertebral-basilar insufficiency are:[4]

(a) paralysis or weakness (drop attacks)—may involve all four limbs
(b) sensory losses
(c) vestibular auditory disturbances (vertigo, nausea, and hearing involvement)
(d) ataxia
(e) diplopia
(f) occipital headache

Recurrent episodes of transient cerebral ischemia may be referred to as saltatory progressive disease in which there is a step-like

worsening in time, which is typical of cerebrovascular atherosclerosis.[5]

A few other important items must be noted when obtaining the history.

(a) hypertension—which predisposes to hemorrhage
(b) hypotension—may cause cerebral infarction; e.g., myocardial infarction or blood loss
(c) cardiovascular disease associated with emboli and embolic phenomena elsewhere in the patient
(d) minor trauma—predisposing to subdural hematoma
(e) effect of neck movements is important; e.g., hypersensitive carotid sinus
(f) use of alcohol, anticoagulants, anti-hypertensive drugs, or psychotropic medication

Physical Examination

In addition to a routine physical examination, a complete cardiovascular and neurologic examination should be done with special attention to palpation and auscultation of the carotids, as well as carotid sinus massage. Carotid artery palpation may reveal a stronger impulse on one side. This may be due to contralateral common carotid obstruction or ipsilateral internal carotid block with increased flow through the external carotid artery.[6]

Carotid auscultation may reveal bruits in a small proportion of cerebrovascular obstructions. Bruits may also be heard in the absence of pathology; and, therefore, auscultation also is not of great help to the clinician.[7]

At times, there may be delayed or diminished radial or brachial pulsations on examination, especially following exercise of the upper limbs, that so-called subclavian steal syndrome.

The carotid sinus syndrome may be provoked by massage of each carotid sinus, one side at a time: but only with electrocardiographic monitoring.

Ophthalmodynamometry

This indirect measure of retinal artery pressure will reflect the status of the carotid artery. The simplest method[8] is to press the spring gauge against the conjunctiva and note the pressure at which the patient reports uniocular blindness. Local anesthesia may be used. The test may also be done by observing the retinal artery with the ophthalmoscope and noting when the artery blanches.[9] This reading is the retinal artery pressure in grams and is equal to about one-half of the pressure in the brachial artery in millimeters of mercury. The pressure in the two eyes is normally equal. Over 70 percent of patients with carotid insufficiency have lowered pressure on the corresponding side.[10] However, this may be apparent only after standing for three or four minutes (persistent orthostatic hypotension).[11] Ophthalmodynamometry is easy, simple, and can be done by any physician.

The disadvantage of the procedure is that the information it gives does not definitely localize the site of the pathology in the carotids. Only *suggestive* information can be obtained in reference to the vertebral-basilar artery system, when the retinal artery pressure is compared to the brachial artery pressure. Uniocular pathology (e.g., glaucoma or uveitis) invalidates results and good collateral circulation may mask a carotid lesion.[9]

Spinal Tap

A second important procedure is *lumbar puncture*. It is indicated in every "stroke" patient when no evidence of increased intracranial pressure is manifested by papilledema in the eye grounds. The procedure is simple, easy, and can be performed by any physician. The fluid pressure should first be determined. The fluid is then examined for red blood cells, xanthochromia, protein content, and the other constituents. The pressure is normally less than 180 millimeters of water, and may be elevated in tumor, hemorrhage, venous thrombosis, or obstruction.

Red blood cells will be noted if the needle-trauma caused bleeding. The red cell count now will be decreased from first to third tube. If the fluid is examined within one hour, the presence of crenated red bloods cells suggests an atraumatic procedure. Other causes of erythrocytes in the fluid are: hemorrhage, subarachnoid or intracerebral, embolus,

and cerebral venous thrombosis. Red cells are absent in cerebral thrombosis and in small intracerebral hemorrhage. Twenty per cent of all intracerebral hemorrhages do not extend to the ventricular system and thus the spinal fluid is clear.

Xanthochromia is present in (a) intracranial bleeding, (b) hyperbilirubinemia, (c) brain tumor, (d) meningitis. The glutamic oxalic transaminase (G O T) is elevated in the spinal fluid a few days after infarction.[12]

In most cases the spinal fluid examination will help in making a diagnosis. Sometimes, however, lumbar puncture findings may actually conceal the diagnosis; e.g., a small cerebral hemorrhage. On rare occasions, spinal tap may be hazardous; it may reactivate a hemorrhage or cause brain stem herniation.

Roentgenography of the skull is of only limited value as a diagnostic aid. A shift in position of a calcified pineal gland or demineralization of posterior clinoids following chronic increased intracerebral pressure or skull fractures are the only signs that may be of assistance in the differential of the stroke syndrome.

Electro-encephalography

The tracings are usually non-specific or normal in cerebrovascular disease but may be helpful in establishing the diagnosis of a brain tumor. Serial tracings show evolution and resolution of cerebral infarction, but these are expensive for the patient.[13] Electro-encephalograms are not universally available, and specialized training is required for their interpretation.

Angiography

Four-vessel arteriography is now the best available means of evaluating cerebral vasculature. At one time this was a hazardous procedure with about a 13 percent morbidity and mortality.[14] More recently, refinement of technic (such as utilization of retrograde brachial injection) has led to much lower mortalities. In one series of 950 cases[15,16] the morbidity was less than one percent and there was only one death from the procedure.

This procedure requires special equipment and training. It should not be undertaken "routinely." Indications for angiography are not yet clearly established, but when the diagnosis is in doubt (and a potentially reversible lesion may be present) or when reconstructive vascular surgery is contemplated, angiography should be done. These studies also permit appraisal of the extent and precise localization of vascular lesions as well as demonstrating congenital vascular anomalies.[15]

A newer technic is *radioisotope encephalography*. This is a recently developed, fast, simple, accurate procedure for intracerebral localization best suited to define space occupying lesions and aids in differentiating these from cerebrovascular disease.[17] The equipment is expensive and is not available in all institutions.

Other procedures include:

(1) *Fluorescein circulation* time is a method of determining circulation time from arm to retinal vessel, through each carotid system separately. A difference in circulation time of greater than one or two seconds is significant for carotid obstructive disease on the side with delayed appearance.[18]

(2) *Echoencephalography* is a simple way to detect midline displacement of the brain.[19]

(3) *Rheoencephalography* is not used with any degree of frequency. It is a procedure for determining cerebral hemodynamic changes by monitoring electrical conductivity changes of alternating current applied to skull with cutaneous electrodes.[20]

(4) *Pneumoencephalography* and *myelography* are neuro-radiologic studies.

Surgery is sometimes feasible for vascular lesions causing transient cerebral ischemia, saccular aneurysms, arterio-venous malformations, intracerebral hematomas, and some non-cerebrovascular diseases.

Medical Management

A—*General Therapy:*

(1) Bed rest with or without elevation of feet.

(2) Maintenance of fluid electrolyte, and caloric balance.

(3) Prevention of infections, decubiti, and contractures.

(4) Adequate treatment of associated hemo-cardio-vascular disease and therapy for other co-existing disorders.

(5) Psychological counseling.

(6) Physiotherapy.

All of these contribute to the essentials of general management.

B—*Specific Therapy:*

(1) Carbon-dioxide (5 percent) and 95 percent oxygen by inhalation is of questionable value; but it may be used.

(2) Stellate ganglion block is now considered to be of little value.

(3) Vasodilators probably have very little effect on sclerotic vasculature.

(4) Thrombolytic agents are promising but still undeveloped.

(5) Anticoagulants should be used for transient ischemic attacks and thrombosis in evolution, unless otherwise contraindicated.[21] They may also prevent recurrences of cerebral emboli but will not help the existing neurologic deficit that follows an embolus.[21]

Some of the more important contraindications to the use of anticoagulants are:

(a) Any past or present hemorrhagic disorder.

(b) Hepatic or renal dysfunction.

(c) An unreliable patient, or uncooperative family.

(d) Lack of laboratory control.

(e) Severe hypertension.

(f) Evidence that the cerebrovascular disease to be treated is neither a transient ischemia nor a thrombosis in evolution nor a cerebral embolus.

Summary

We have discussed recent advances in the diagnosis, prevention, and treatment of cerebrovascular disease. Since two million people in the United States are estimated as being afflicted with this condition, the need for early diagnosis and immediate treatment is evident.

The importance of the role of "small strokes" in the overall picture has been emphasized. Many different tests and their relative value have been discussed.

Surgical treatment is important in such lesions as transient cerebral ischemia, saccular aneurysms, and arteriovenous malformations; more emphasis was placed on medical management.

Progress has been made in the past two decades, giving hope to those who formerly were abandoned as hopelessly handicapped people. Greater strides will be made in the near future, particularly because of the stress now being placed on the rehabilitation of these patients to more useful lives.

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2130 Millburn Avenue

Residential treatment in a special unit may be the only workable treatment for some children with intractable asthma.

Institutional Care For Asthmatic Children*

Martin Green, M.D./Atlantic City

Convalescence is defined[1] as the "gradual recovery of strength and health after a disease." This is the underlying concept governing the selection of children for institutional, asthmatic rehabilitation centers. Such a child leaves a family group that has been disorganized by his severe asthma. On admission to the asthmatic unit, he is frequently wheezing severely, has a "hangdog" expression, and the outlook of a permanently invalided patient. In residence, the child receives active allergic and psychiatric treatment. When he is discharged, he is frequently improved to such an extent that he can join his own family group without disrupting their entire home life.

The advantages of institutional care of the child with persistent severe asthma was recognized in 1930 by Peshkin.[2] This followed observations that children with severe asthma often improved during hospitalization with practically no treatment of the asthma and little change in the immediate aero-biological environment. Peshkin[2] defined intractable asthma as "severe, perennial asthma, requiring frequent hospitalizations and not responding to the accepted standards of allergy practiced in the child's own community." Ten percent of all asthmatic children fall in this group. Tufts[3] has estimated that there are over two hundred thousand such cases in the United States.

About 700 institutional beds are available in the United States for children with intractable asthma. The largest institutions are in Denver. Smaller asthmatic rehabilitation centers, such as the one at the Betty Bacharach Home in Longport (Atlantic City), New Jersey, are in Tujunga, California; Tucson, Arizona; Palo Alto, California; Cincinnati, Ohio; Miami, Florida; Philadelphia, plus one just outside of New York City. Because of the one to two year period of convalescent care for these asthmatic children, only a small proportion of applicants can be admitted.

The Betty Bacharach Home is a general pediatric convalescent home at Longport, New Jersey on Absecon Island. Steen[4] states that climato-therapy is important in the treatment of intractable asthma, but Unger[5] disagrees. Climate probably plays little role in the results achieved in the treatment of intractable asthma, but there is certainly some advantage as noted by Gelfant[6] in the fact that Absecon Island is a relatively pollen free area.

The asthmatic rehabilitation unit occupies the entire third floor of the Home. This floor is divided into four bed cubicles. The cubicles are glassed from three feet above the floor. There are curtains in all the cubicles, but the children can be observed during sleeping hours from the nurse's station. An isolation room is available. The ward's easterly exposure overlooks the ocean, and the westerly exposure looks on Egg Harbor Bay.

There are two large play rooms on the ward. Other facilities include a large, well equipped gymnasium; a large auditorium with a stage; a well lit, airy, and cheerful dining room; a swimming pool; three large classrooms; and an outside play yard.

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The staff consists of the physician in charge, a research assistant (usually a senior medical student), a clinical psychologist, a social worker, four teachers, a physical therapist, a speech therapist, and a physical education teacher. Nurses, practical nurses, and aides supervise the immediate care of the children. Physicians on the staff of Jefferson Medical College in Philadelphia act as consultants. Their advice and participation in this program have been extremely advantageous.

Admission Procedures

The criterion for admission is intractable asthma. Tufts[7] enhanced Peshkin's definition of intractable asthma by stating that a thorough allergy survey must have been completed and allergy therapy must have been continued for at least one year with little or no results. Children from ages two to thirteen years are admitted. The intractability of the asthma is determined on the basis of the number, severity, and duration of attacks; frequency of hospitalization; extent of treatment of the allergic components; and the existence of emotional problems.

When the child is admitted, the parents are informed that all admissions are for a trial period of one month, and that visiting is permitted only on weekends. During this trial period, the staff determines whether the child will cooperate in and benefit from group living. The new patient is placed in a cubicle with children of similar age and of the same sex.

Admission procedures include a history, physical examination, blood count, roentgenogram of the chest and sinuses, urine analysis, nasal smears, circulating eosinophile counts, tests for pulmonary function, a gamma globulin determination, a sweat test, an electrocardiogram, complete skin testing, psychometric testing, psychiatric evaluation, an electro-encephalogram, and elimination diets when indicated. Treatment is based to some extent on the findings in these examinations, but our approach on admission to the convalescent home is to do as little as possible for three months except to attempt to wean the patient from steroids, if admitted on this drug, and to complete the diagnostic evaluations. During this observation period the asthmatic child usually responds to the separation from his own home environment and his new residential status in a manner which is usually characteristic of his entire stay in the convalescent home

Diagnosis

The etiologic diagnosis serves little purpose in handling the intractable asthmatic in the convalscent home. A useful working classification must be the basis for both diagnosis and treatment. The following classification, modified from that of Bernstein and Purcell,[8] depends upon the status of the child's asthma three months after admission to the convalescent home.

1. Rapid Remitters—Asthma clears within two weeks and child remains free of asthma.
2. Intermittent Asthma—Asthma is partly controlled without steroids following admission.
   a. Mild—Child is rarely, if ever, incapacitated by asthma and can carry on normal activities.
   b. Severe—Child is partly incapacitated and normal activity is restricted.
3. Steroid Dependent—Asthma can be controlled only by continuous administration of steroids.
4. Non-Responders—Asthma does not respond to any treatment.

Treatment

The rapidly remitting asthmatic child remains in residence at the Betty Bacharach Home for at least one year, with no allergy treatment except observation, psychological direction, and an educational program paced to his physical and mental capabilities. In one instance an allergic child, after nine months in the Home, complained bitterly that "he had forgotten how to wheeze."

The mild intermittent asthmatic group is treated similarly to the rapid remitters, except that they will receive hyposensitization to seasonal allergens when skin test positive and observation through a specific season confirms this necessity. This group of patients always receives hyposensitization to causative aller-

gens before discharge. It is possible that with the resumption of the intimate home ties and the additional readjustment problems, the allergic tolerance of the child will be low as compared to the tolerance while in a residential status in the convalescent home. A build up of tolerance to a specific allergen possibly responsible for a portion of the total allergic load might avoid an early retrogression to his previous intractable asthmatic condition.

The therapeutic approach to the severe intermittent, the steroid dependent, and the non-responding asthmatic is much more vigorous. Treatment, where indicated, consists of environmental allergen control, elimination diets, hyposensitization, bronchodilators, particularly with intermittent positive pressure breathing, breathing exercises, psychiatric guidance, gamma globulin, and steroids.

Environmental control of allergens is practiced throughout the convalescent home, but is emphasized in this instance. The standard precautions for reduction of exposure to house dust and feathers are constant. Elimination diets are used where indicated, particularly to confirm the history and the results of skin testing and immuno-precipitation procedures. Milk, egg, wheat, and corn are our principal targets, although other specific food allergens are eliminated when necessary. Interestingly enough, the entire group of children act as secondary guards and call any offerings of any offending food to the attention of the affected child and the dietitian.

Hyposensitization when indicated on the basis of history and skin testing has a definite place in the treatment of these three groups. Results are difficult to evaluate because of the number of additional factors other than the seasonal allergens which contribute to the child's asthma.

Steroids are frequently the only means of controlling persistent severe asthma when other therapeutic measures are ineffective. Ninety five percent of the children in the Betty Bacharach Home have had a therapeutic trial of steroids before admission. Many of them were still on steroids when admitted to the Home. An attempt is made to wean all of the children from steroids. Originally, the proportion of children remaining on steroids was higher than at present. Our total census is usually thirty, and it is rare now to have more than three patients on steroids at any one time. The problem in steroid therapy is not the inherent dangers in the cortisone products, but the fine balance of therapeutic necessity as a means of avoiding continuous asthma and crippling emphysema. Itkins[9] finds it necessary to place many chronic persistent severe asthmatic children on steroids to avoid the permanent lung changes in emphysema. Management of the steroid-dependent group must take into consideration the progressive possibility of permanent lung changes and emphysema if the asthma cannot be controlled.

The use of gamma globulin is controversial in severe asthma. Green, *et al,*[10] screen asthmatic children for immunologic non-responsiveness. If non-responsive, the nasal smears will consistently show many bacteria with little or no phagocytosis or agglutination of bacteria. If the child is given an injection of gamma globulin equivalent to 0.2 cubic centimeters per pound of body weight, there will be a reversal in the findings in the nasal smear and the clinical picture. The nasal smears will show bacterial agglutination and phagocytosis, and the asthma will be aborted or much improved. This phenomenon apparently occurs in about 3 percent of chronic asthmatics. Two hundred persistently severe asthmatic children have been screened by nasal smears. Seven immunologic non-responsive asthmatic children have been diagnosed and treated. Of this group, five have done well, one moderately well, and one poorly.

For these last three groups, we have a total psychotherapeutic approach with emphasis on a well rounded routine of exercise, outdoor play, and individual therapy. Each child is evaluated by our clinical psychologist. A psychiatrist is available for consultation. Each case is reviewed periodically at staff meetings.

Psychotherapy, if necessary, is undertaken by the psychologist under the guidance of the psychiatrist. If psychiatric guidance is desirable for parents, arrangements are made with a psychiatrist or a psychiatric clinic in the area of the parents' residence.

The social worker concentrates his efforts on these last three groups. He is trained in the evaluation of household allergens including molds. He interviews the parents and the child on admission and makes periodic visits to the child's home to establish and improve rapport between the child, the parents, and the Betty Bacharach Home; to instruct the parents on the procedures for preparing and maintaining a household allergen and mold free area; to orientate the parents on how to handle the child when he returns to their home; and to see that the parents get counselling if they need it. It is planned to have him visit all discharged children at least once every six months for follow up reviews.

Results

Of the first 116 children admitted to the Betty Bacharach Home, 33 were rapid remitters. Eighteen parents of rapid remitters returned follow up questionnaires six months after discharge of the child. Ten reported their child much improved, four stated that their child was improved, four the same, and none were worse.

Forty-seven children were classified as intermittent mild asthmatics while in the Home. Twenty-two parents answered the six-month follow up questionnaire. Ten of their children were called "much improved;" seven were "improved;" one was the same; and four were worse. Twelve parents of 20 children classified as intermittent severe asthmatics while in the Home answered their questionnaire. Four were much improved, two were improved, four were the same and two were worse.

Sixteen cases of intractable asthma could not be controlled by any method other than steroids. Seven parents answered the questionnaire and reported that three were much improved and four were improved over the preconvalescent home status. Four of the children were still on steroids. The two non-responders could not be controlled even with large doses of steroids.

Five of our children have died. Two were intermittent severe asthmatics and three were steroid dependent. Two died in the Betty Bacharach Home, one within forty eight hours of admission. The other three had been discharged to their own home environment.

Eighty six percent of the children with persistent severe asthma improved when admitted to the Betty Bacharach Asthmatic Unit. According to the parents, 64 percent of these children had maintained their improvement to varying degrees six months after discharge. If these children had been permitted to remain in their own homes it is possible many of them would have progressed to emphysema, chronicity of complaints, restricted personality development, and limited physical tolerance. The interruption in the progress of their chronic lung condition is in itself a valid reason for the residential care of the child with persistent severe asthma. Since 27 percent of these children were completely controlled in the Home and an additional 59 percent showed either marked or moderate improvement, this type of care is almost a necessity in the intractable asthmatic child. Whether the reason for improvement is separation of the child from his emotional problems or from the household and atmospheric allergens, both reasons emphasize the need for this type of institutional care.

Summary

1. Residential care of the child with intractable asthma in an institutional asthmatic rehabilitation unit is a feasible method of treatment.

2. The physical plant, the ancillary medical personnel, and the educational system contribute to the welfare and improvement of the child with intractable asthma.

3. Eighty-six percent of the children with intractable asthma show observable improve-

ment when institutionalized. Twenty-seven percent are controlled completely.

4. Sixty-four percent of the asthmatic children had maintained their improvement in varying degrees six months after discharge from the asthmatic unit as reported by the parents.

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1922 Pacific Avenue

Our State's Burgeoning Population

More people move into New Jersey than out, and as a result, the State's population is increasing by leaps and bounds. New Jersey, with almost 880 persons per square mile, has the highest population density of any state in the nation. On July 1 a year ago, our population was estimated at 6,062,540, an increase of 8.8 per cent above official 1960 population figures. There are many more residents now.

Growth generally has taken place over the entire state, but shifts in population from one area to another reflect developments in industries, housing, recreational facilities, and highway and rapid transportation routes.

Albert R. Post, chief of our State's Bureau of Commerce, explains that migration of people from other states to New Jersey increases our population. On the other hand, the net "natural" increase in the years since 1960 has been higher than during the previous decade, accounting for 347,790 net births over deaths between 1960 and 1964.

Every county in New Jersey has an increased population, with the exception of Hudson, which has registered a 1.4 per cent decrease. Increases in other counties range up to 25 per cent in Ocean County. Burlington County with a 19 per cent increase, Somerset, also up 19 per cent, and Monmouth and Sussex, each with an 18 per cent increase, are other areas with gains above average.

Some of the municipalities that have had spectacular growth since 1960 include Stratford Borough in Camden County, which showed the greatest gain of all the municipalities: 98 per cent over the period; and South Toms River Borough in Ocean County, which grew 93 per cent. Other county populations have increased the following estimated percentages over the past four years:

Atlantic, 6.8; Bergen, 9.5; Camden, 9.6; Cape May, 5.0; Cumberland, 8.5; Essex, 1.8; Gloucester, 11.7; Hunterdon, 9.8; Mercer, 6.9; Middlesex, 14.9; Morris, 17.0; Passaic, 7.6; Salem, 6.0; Union, 7.9, and Warren, 7.5.

The medical profession is here offered an opportunity to take part in a unique team approach to a greater society.

Medical Care In Project "Head Start"

John C. Bullitt*/Trenton

Thousands of physicians throughout our country are now taking part in the medical aspects of Project Head Start, the War on Poverty's program for pre-school children from low-income families.

In New Jersey over 11,000 children have been registered. More than 3400 professional and volunteer workers are carrying out a unique and massive program to help prepare these youngsters to enter local school systems this fall.

New Jersey is contributing $270,000 of the $2,000,000 total cost; the Office of Economic Opportunity is furnishing the balance to rent facilities, train and pay doctors, teachers, and social workers participating in Project Head Start. This is our nation's first major attack on the country's poverty problem through an attempt to give pre-school children of the poor a chance to catch up with their contemporaries *before* kindergarten or first grade and thus reduce the chances of a first-grader becoming drop-out material.

A three-way program is directed at the whole child, including medical examinations and care, social services for him and his family, and a pre-school educational project. The program was blue-printed by Robert E. Cooke, chief of pediatrics at Johns Hopkins University. Other physicians on the committee are: Dr. Edward Perry Crump, Professor of Pediatrics at Meharry; Dr. Edward Davens, Deputy Commissioner, Maryland State Department of Health; and Dr. Reginald Lourie, Director of Psychiatry, Children's Hospital, Washington. Program Director is Dr. Julius B. Richmond, Dean of the Medical Faculty at Syracuse.

The emphasis on health is due to the high incidence of physical defects customarily found in under-privileged children. About one-third of the children from low-income families who will enter kindergarten or first grade are poorly prepared for school. Unless they receive special help they are destined to fall behind their more fortunate classmates.

On the basis of previous experience, it is expected that partial blindness will be found in 4 per cent; and another 10 per cent will have hearing difficulties. As many as 50 per cent will have no record of immunization against diphtheria or tetanus. Many active cases of tuberculosis and many, many contacts will probably be discovered during the examinations.

The examinations are expected to reveal 5 per cent of the children with nutritional deficiencies and 2 per cent mentally retarded.

The significance of these statistics is not known to the general public. Few know that the millions of measles cases each year *can* cause lung and brain damage to children living under poor conditions and suffering from a lack of proper care.

Professional associations like the American Academy of Pediatrics, American Psychiatric

* Mr. Bullitt is Director of the New Jersey office of Economic Opportunity.

Association, American Dental Association and the American Nursing Association have offered the services of their membership. The National Society for the Prevention of Blindness is training volunteers to conduct visual screening examinations preliminary to the more thorough examinations by the doctors.

Head Start's medical examination will be the first for a great majority of the 500,000 children enrolled in the program.

Fundamental to Head Start is the belief that the early childhood years are the most critical point in the poverty cycle, a period when learning patterns, emotional development, and the formation of individual expectations and hopes takes place at a rapid pace. For the child of poverty there are early observable deficiencies in these processes which lay the foundation for a pattern of failure—and thus a pattern of poverty—during his entire life.

Pre-school years are important in offering an opportunity to break the "poverty cycle" and, through the child, to gain access to the family and its problems. A successful program must be inter-disciplinary, involving activities generally associated with the fields of social service and education as well as health.

The medical examination constitutes the first phase of the medical activities of Head Start. Equally important is the referral of children to community facilities for treatment and a follow-up by a public health nurse or social worker to make sure that the recommended steps have indeed been taken. In many cases, families are unaware of the existence of free health services in their community.

The American Academy of Pediatrics is offering appraisal services. Similar cooperation is being extended by medical school faculty members throughout the country.

Apart from the sheer size of the effort (an anticipated 100,000 registrations quickly grew to five times that number), an unusual feature is the participation of the parents in their children's activities. Parents work in the program as aides, help in program planning and many non-professional jobs, depending on their availability and special aptitudes or interests. An important objective is to educate the parents to the need as well as the existence of local health services.

Head Start is building on a solid foundation which has existed for many years, although past school-centered programs have been available only to small numbers of children.

The new program serves children bringing with them more than their share of hurts from the past, so that working with them in small groups has seemed especially important. Children from low-income families are also likely to have more need for comprehensive medical, psychologic, and welfare services; access to these resources is important.

Box 2748

A Medical Guide for Pregnant Women

A new 177-page "Medical Guide for Pregnant Women" is now available. Published by Bantam Books, the paperbound handbook can be purchased at quantity discount prices from The Benjamin Company at 600 Fifth Avenue, New York 20, New York.

The purpose of this authoritative guide as described by author Dr. Robert E. Hall is "to satisfy the healthy intellectual curiosity of the modern woman." Dr. Hall describes the development of the fetus, complications of pregnancy, medication, how to control weight, possible danger signs, what to expect in the hospital, natural childbirth, the effects of cigarette smoking, and the use of flourides. A single copy sells at 75¢.

If your patient is entitled to disability benefits for visual impairment, he will get them swifter if you submit adequate reports.

Disability Reporting on Visual Impairments

Herbert L. Moskowitz, M.D./Millburn

Patients covered by social security may be eligible for cash benefits when they are so severely disabled by visual or other sensory impairments that they can no longer perform any substantial gainful work. The impairment must be one that can be expected to result in death or to be of long-continued and indefinite duration. The decision to pay benefits is based primarily upon the medical reports received from the applicants' physicians. For New Jersey residents, the determination of disability is made by a physician of the Disability Unit of the New Jersey Rehabilitation Commission, working with a specialist in vocational evaluation. This article and the appended *Reporting Outline for Medical Evidence on Ophthalmologic Diseases* are designed to help the physician in completing disability reports on visually impaired patients.

Although cash benefits go only to those unable to do substantial work, a permanently blind patient may qualify for the "disability freeze" even if he is working. The "freeze" protects his rights to future benefits. Permanent blindness is defined by statute as visual acuity of 5/200 or less in the better eye with the use of a correcting lens. An eye in which the visual field is reduced to 5° or less in greatest diameter is also considered "permanently blind," even if central visual acuity is good. If a statutorily blind worker finds that his condition makes him unable to continue working, he may be eligible for disability benefits *in addition* to his "freeze" protection. As with other impairments, a visual problem must prevent work for six full months before benefits can be paid.

A person may be disabled by a severe visual impairment even though he does not meet the statutory definition of permanent blindness. For him the determination will be made exactly as it is for other persons: that is, he meets the general definition of disability if he is unable to engage in any substantial gainfull activity by reason of his impairment. Here, the criteria of industrial blindness generally apply. This means that the patient having a corrected visual acuity of 20/200 or less in the better eye, or a visual field with W-3/330 test object of 10° or less, will usually be considered disabled. When both visual acuity and visual field loss are present, a percentage computation of these defects is calculated to determine the patient's total visual efficiency.

A judgment as to the severity, expected duration, and remediability of the patient's visual impairment is made by the reviewing physician on the basis of the clinical history, physical and laboratory findings, and visual capacity observations. This is usually reported by the treating physician from his records or obtained by him as the result of an additional examination. The treating physician who understands what is needed can supply the necessary information on his initial report. By doing so, he will not only save his own time but will also speed the decision on his patient's claim. Some patients are sent by the Disability Unit for specific evaluation by an ophthalmologist who is certified by the State for that area.

On the reporting form, show the visual acuity in graduations down to absence of light perception, especially where acuities of less than 20/200 are involved. A statement like "less than 20/200" does not adequately describe a patient's vision when a determination of statutory blindness is necessary. The findings should be carefully dated. A *diagnosis* is essential because it defines the disease process and helps determine or predict the duration

of the impairment. Since benefits cannot begin until after the patient has been disabled for at least six full months, the date of findings is necessary to establish the beginning of this six-month waiting period and the first month of payment.

After findings have been completely reported, a prognosis based on those findings is helpful. Some visual impairments (like cataracts) severely restrict vision but are only temporary in nature since successful removal will frequently restore vision to a point where it will allow the patient to return to work. Other forms of available therapy should be defined and the chance of success estimated.

Careful attention to these points will aid in making a prompt and equitable determination of disability, and avoid repeated correspondence or telephone calls to the treating physician and the inevitable delay to the patient.

The following case report shows how a brief medical report can often contain all of the information needed to evaluate a disability applicant.

This 62-year old woman first saw me June 1, 1962 because of poor vision (R=20/400, L=c.f. 15 ft.) which was attributed to cataracts in both eyes. The right eye cataract was operated November 5, 1962. This eye was corrected to 20/15 vision on January 5, 1963. The left eye was operated April 2, 1964, and now has 20/50 vision. The visual fields, fundi and ocular tension are normal. The patient was last seen August 8, 1964.

John Q. Smith, M.D.
Sept. 15, 1964
116 Millburn Avenue

Although this report is brief, it contains all of the information needed to show that this applicant has sufficient vision to perform many types of vocational activity.

The following outline illustrates the types of evidence used to make decisions on visual impairments. It is not a formula for the documentation of all cases. It has been made broad and inclusive though not exhaustive, because its purpose is to remind the user of the *kinds* of evidence needed and not to dictate his selection. The reporting physician will decide which facts must be procured and reported to support a diagnostic, prognostic, and functional conclusion. No outline can ever replace professional medical judgment. Here are some points which the attending physicians should consider putting in his report:

1. Brief summary of medical history, if pertinent.
2. Ocular history—date of onset of poor vision is important, if definable.
3. Visual acuity best corrected; and glasses prescribed, if pertinent.
4. Visual field: 3 millimeter white object at 330 millimeters on a perimeter (6 millimeters white for aphakia).
5. Description of ocular disease (movement, lids, cornea, lens, retina, choroid optic nerve, and so on).
6. Tension, if necessary.
7. Diagnosis.
8. Therapeutic possibilities.
9. Prognosis.

Benjamin Franklin in Medicine

In 1772 a portrait of Benjamin Franklin, made in Paris, designates him *docteur en medicine*. Franklin was, of course, not an M.D. and never said he was. Though he had an LL.D. degree (St. Andrews 1759) and was generally called "Dr. Franklin" in Europe, the appellation "doctor" in that time and place generally meant what it said literally: a learned man.

However, Franklin made many contributions to medical understanding. An interesting 19-page brochure called *Benjamin Franklin in Medicine* is available from Aloameon Editions at 2421 Webb Avenue, University Heights, New York 10468. This is a translation of a 1956 pamphlet originally written in Italian by Giovanni Arcieri, M.D.

All doctors have a stake in the development of community mental health centers and in their coordination with general hospitals.

The Community Mental Health Center*

A Resource for the Psychiatrist

William Furst, M.D./East Orange

In this best fed and wealthiest country in the world, with the highest income per capita, one of the highest literacy rates, with the greatest number and best equipped hospitals, the finest medical schools and research centers, and the greatest number of trained psychiatrists, we face the appalling statistic that one out of every ten children born in 1960 will spend some time of his life in a mental hospital. That every other hospital bed in the United States is constantly occupied by a mentally ill person, some 500,000 is no less shocking. Furthermore, an increase of 126,000 mentally retarded children per year cannot be disregarded. Yet, in the U.S.A. we have only one psychiatrist for every 16,000 citizens. Three fourths of all counties in the United States have no psychiatrist. Only 20 per cent of the general hospitals in the United States have psychiatric beds. It is, then, no surprise that the American Medical Association (through its Council on Mental Health) has declared mental illness and mental retardation to be our Number One public health problem.

This country will be forever grateful to the sensitivity and determination of our late President Kennedy, through whose efforts federal legislation in 1963 set the stage for a new approach to the problems of the mentally ill and retarded. Influenced by Dr. Robert Felix, then the Director of the National Institute for Mental Health, community mental health centers will shortly be developed; hopefully one per every 100,000 population area.

The modern, well trained psychiatrist, with a minimum of 15 years of preparation, is a highly qualified internist, quite removed from the former concept of the isolated specialist using a highly esoteric language, whose therapy continued for years. There are numerous therapeutic approaches in psychiatry today which compare favorably with, or even exceed in value, the methods available in other chronic diseases. Agitated, maniacal patients may be psychopharmacologically controlled. Suicidally driven personalities may be brought out of danger by intensive electrotherapy. The nuances of disturbed brain physiology may be recognized by electroencephalography. These, with the tremendous advancements made through the insights generated by psychoanalytic explorations, have qualified psychiatrists for an increasing responsibility in the diagnosis and treatment of complex medical problems.

Congress has appropriated $150,000,000 for the establishment of community mental health centers in this country. Legislation is pending for an additional $700,000,000 for services and staffing of these centers. For the first time, guidelines for a coordinated and integrated

* Presented at the Annual Meeting of The Medical Society of New Jersey in Atlantic City, May 18, 1965.

program for the mentally ill and the retarded are being formulated which will utilize the available skills and accumulated knowledge to return the maximum number of patients to their places in society.

The concept of the *community mental health center* will vary, depending on the locale, funds, personnel, and community sophistication. Let me here present my concept of what a community mental health center should be in terms of its overall frame of reference. This model was formulated for Essex County, which has one of the highest population densities in the country. This visualizes the general hospital as the hub of the wheel from which the spokes of other services will radiate in integrated referral.

Imagine, if you will, an emotionally ill person referred to the emergency admission ward in the general hospital. Temporary care of less than 24 hours may suffice for some disturbed patients who might then be sent to their private physicians or to an out-patient clinic. It is hoped that each general hospital will assign at least one percent of its beds for temporary psychiatric care. If further study and treatment are indicated, a psychiatric ward of 5 to 10 beds per 100 bed capacity should be available. Experience in numerous psychiatric hospitals emphasizes the importance of flexibility in making such beds available on a day, night, or weekend basis. While the average general hospital psychiatric patient care is 14 days, opportunity should be available for such continued treatment up to 30 days.

Modern intensive treatment permits a remarkable improvement for mentally and emotionally disturbed patients. Within two weeks they may be discharged on psychopharmaceutical controls, continuation psychotherapy, or ambulatory electrotherapy. Referral may be to the private psychiatrist. Where none is available, referral may be to an adequately staffed out-patient clinic for follow-up supervision and drug control.

The integration of additional clinical facilities (either as an integral part or peripheral projection of the community mental health center) should eventually be made available. A day-care treatment center may reduce the intramural case load. Where personnel is available (such as at the Boston State Hospital), a home visiting team composed of a psychiatrist, psychologist, and social worker may perform a unique service by avoiding hospitalization entirely through home care.

One of the greatest deficiencies today is in the area of child mental health. In Essex County, with its population close to one million, there is no residential treatment center for disturbed children under 14 other than at the limited facilities of the Garden School.

A central information processing center will eventually be needed to prevent the reduplication of studies, testing, and therapeutic approaches for many mentally ill patients. The general hospital should be integrated with a family service agency, mental retardation clinic, occupational and rehabilitation clinics, a public offenders and alcoholic and drug addition clinics. Then the general hospital, as the center of the community mental health center, takes on increasing significance. A geriatric clinic, with its potential for caring for a great number of elderly people in conjunction with its associated services, will be of great community service. Such an integrated system permits the miracles of modern medicine to be utilized to the fullest capacity and brings psychiatry back into the mainstream of medicine, where it belongs.

Education of the public through image projections of what can be offered will greatly help de-sensitize the community fear of mental illness and avoidance of early help. By removing the stigma of "being sent away," the patient—proximate to his family in the community, treated as if he were medically ill with promptness and efficiency—utilizes his inherent capacity to assist in his own recovery. The psycho-debilitating effects of prolonged hospitalization are well known. In addition, family responsibilities for the care of the emotionally ill become lessened after the state or county assumes protective custody. Main-

taining the patient in the community makes the family more responsible for their role-playing in assisting patient recovery.

Such an integrated program, utilizing all the cooperating disciplines in psychology, social work, occupational and rehabilitation and pastoral cooperation, in addition to the auxiliary help that laymen in their various organizations may provide, will be of inestimable value. Public health and sociologic studies of such an integrated program will permit a definitive examination and approach to the prevention of mental illness.

Dr. Karl Evang, Director-General of the Health Services of Norway, speaking at the opening of the Yale University Laboratory of Public Health, stated: "Nowhere do most existing medical care systems demonstrate their shortcomings more clearly than in the handling of the mentally ill." Solution of the problem, he said, requires a halt to "lack of scientific insight, traditionalism, vested interests, out-moded regulations, lack of proper institutions and personnel," and "the deeply-rooted unwillingness, even in the medical profession, to know oneself."

It is hoped that the physicians of this state and our medical society will lend every assistance in struggling with what may appear to be a grandiose plan. I trust that our late President Kennedy's "bold new approach," so well defined in his historical Public Law 88-164, will be aggressively supported by The Medical Society of New Jersey.

49 South Munn Avenue

Medical Manuscript Editing Service

The American Medical Writers' Association provides a Medical Manuscript Editing Service, available to non-members of the Association. The charge is $7.50 for the first 1,000 words plus $7.50 for each additional thousand or fraction.

Only manuscripts that are intended for medical journals or kindred publications (from which the authors receive no fees) and not exceeding 5,000 words in length will be accepted for review and editing. This is not a commercial service and does not concern itself with the selling of manuscripts, ghostwriting, or compiling bibliographies.

The Service is intended for medical writers who would like to have assistance. The principal aim of the Service is to help authors say what they want to say with precision, economy, and grace. On the manuscript, the Editor corrects punctuation; capitalization; spelling; misused words, including medical terms; and arrangement of bibliography. The Editor offers a line-by-line criticism of the manuscript covering such points as title, organization, tables and illustrations, sub-heads, and summary, as well as grammar, syntax, and usage.

Many users of the Service are regular contributors to medical literature, and evidence indicates that all who use the Service have been satisfied with the work it does for them.

Manuscripts must be set by first class mail, typewritten, in English, double or triple space, with wide margins at top, bottom, and both sides, written on one side only, and accompanied by return first class postage. The number of words in the manuscript must be stated in the upper right hand corner of the first page; and the fee for the Service, including return postage, enclosed. The author should retain a copy of his paper. All manuscripts should be set to the American Medical Writers' Association, Medical Manuscript Editing Service, Ravenswood Hospital, Chicago, Illinois 60640.

The views here freely expressed by Dr. Brauer have not been officially endorsed by The Medical Society of New Jersey, before whom the author spoke in May 1965.

The Dermatologist, the Cosmetic Chemist, and the New Law*

Earle W. Brauer, M.D./Bronx, New York

Excluding the new nations of Africa and Southeast Asia, the United States of America may be considered a stripling among sovereign governments; yet we have developed one of the most advanced and controlled programs of any civilization known—that for the supervision of drugs, foods, and cosmetics. In the United Kingdom, for example, Parliament is only now considering laws similar to ours. In the interim, however, Britain is functioning under a voluntary program overseen by a committee from chemical sciences, the medical disciplines, and representatives of industry. While, like most Americans, I am proud of our world status in this regard, I would like now to focus attention on certain federal regulations that may injure our pre-eminent position in the science of drugs and cosmetics.

On October 10, 1962 American medicine was drawn into an era of imposed governmental control which may very well prove more restrictive to the future of our profession than was ever considered possible by those who warned against socialized medicine. On this date Public Law 87-781 (the Drug Amendments of 1962) became effective.

Prior to that date, the decision about whether a drug's potential good outweighs any potential hazard was the prerogative of the practicing physician. In October 1962, this right was abdicated to a governmental agency. Now no licensed physician may expect his prescription for a new drug to be honored unless the Food and Drug Administration (FDA) has previously authorized it to be prescribed.[1] The inference may be drawn that this circumstance, along with several other undesirable aspects of the Act (e.g., restrictions on research), has led the American Medical Association to go on record[2] "clearly and emphatically that in . . . its . . . opinion . . . the Drug Amendments of 1962 should not have been enacted." Our parent body believes the few desirable components of the Act are dwarfed by the "dangerous and unwarranted grants of authority . . . bestowed upon the federal government."[2] The AMA, however, is cooperating fully with the FDA in its Herculean effort to comply with the law it must administer.

Prior to 1906, no food-and-drug controls existed; in that year, the first Food and Drug Law imposed limited controls over interstate traffic in drugs. The amendments of 1912 made it possible for the government to take action if false therapeutic claims were made. But governmental action could be successful only if the claim put forth was done so fraudulently.[3]

The great need for governmental supervision became grimly apparent in 1937 following the

* Read May 19, 1965 at Atlantic City before the Dermatology Section of The Medical Society of New Jersey.

"Elixer of Sulfanilamide" disaster in which more than 100 individuals died. A toxic solvent had been used in this elixer to bring the insoluble sulfanilamide into solution. Consequently, in 1938 a New Drug Section was written into the law. This basic statute obliged the manufacturer adequately to test a drug for safety and to report these data to the government before the drug could be legally marketed.[3] There was no requirement in this law to establish the drug's efficacy.

During the decades these regulations were in effect, drug research flourished. In the score of years following World War II, numerous antihistamines, versatile antibiotics, corticosteroids, ataraxics, and many more drug groups were successfully introduced to raise the practice of medicine to a new zenith and to elevate the pharmaceutical industry to a respected position in the economy of American business.

Not all the drugs introduced lived up to the claims made for them. But in our free environment, these fakes were quickly discovered and discarded. Many of the innovations were frequently "me-too" drugs: copies of other preparations on the market or merely combinations of two or more drugs used successfully individually. But this abuse, while confusing to some degree to the practicing physician, often served a useful purpose in reducing the cost of medication in the open market place.

In 1962, many months after the thalidomide dangers were known to the public as well as organized medicine, a crusading spirit surged forth in Washington to seek drastic changes in the very Food, Drug, and Cosmetic Act which kept thalidomide off the American market! An inspired Congress knew no bounds, and the Drug Amendments of 1962 passed both the House and Senate by unanimous vote. Austern[1] reminds us that this was "a unanimity that . . . had never before been achieved in major legislation, not even a declaration of war." With masterful juxtaposition, Austern also recalls[1] that in 1962 there were "41,130 Americans killed in automobile accidents and that no federal legislation emerged on that problem."

It is well recognized that the old law was in need of revision. It is equally well accepted that much of the new law will significantly benefit the citizenry as well as the medical community. What, then, is the basis for the major criticism of the amended Act?

To comply with the requirements of the Act, the cost of investigating new drugs has skyrocketed in terms of dollars and time. This strains the resources of large companies and practically eliminates the small business community. Drug research and development may soon reside solely in the hands of the industrial giants. Also, because of this great cost, many promising drugs with only limited market potential may never be investigated:[4] the expenditure simply could not be justified.

The Act rigidly requires that all clinical investigators must obtain (except in unusual circumstances) a patient's consent before any investigational drug may be prescribed or administered. This can seriously complicate and delay a clinical program. Many hospitals, after consultation with their legal departments, are reluctant to authorize clinical research[5] because of the risk of legal liability.

A clinical investigational program in detail must be filed with the Food and Drug Administration before it can be instituted. It cannot be varied unless a revision of the program is first filed with Washington. It is readily evident what a restrictive burden this places on scientific investigation where variation and adjustment, particularly in the early phases, can be an every day occurrance.

Clinical investigators are expected to be experts, preferably with affiliation at large teaching centers, so that full laboratory and consultative services are freely available. Incidently, their *curricula vitarum* must be filed with the sponsor of the drug who has to affirm that he is satisfied with the professional skill and integrity of the investigator.[6]

If one of you were currently in possession of a chemical which, you felt, had promise as

a drug for topical application; if you were ready to proceed immediately with its investigation, it is conservatively estimated that it would require 5 years before it could be marketed. An oral or parenteral preparation would probably take longer. How about the cost of such a program, exclusive of that expenditure relating to the development of the chemical compound itself? A reasonable figure would be $200,000; this could be considerably higher, particularly if it is an oral or parenteral preparation. Thus one can understand Stetler's fear[2] that these new regulations "impose restrictions on research that may ultimately discourage and impede discovery of valuable new medicines."

Not until 1938 were cosmetics included in the Federal Food, Drug, and Cosmetic Act. Several incidents of injury had taken place to warrant this inclusion. This law provided for serious penalties to distributors or manufacturers whose products could cause injury or whose labelling made misleading claims. Under this Act the incidence of harm caused by cosmetics decreased. When one considers the tremendous exposure cosmetics have in the general population, the infrequent consumer injuries which have been of minor and reversible nature[7] demonstrate the effectiveness of the Act of 1938.

The cosmetic industry understands and accepts the need for regulations that require new cosmetics to meet safety standards before marketing. It is no less reasonable to recognize that a few individuals may suffer minor "adverse effects" from the use of some cosmetics. Even nature hasn't made the strawberry safe for everybody. Kleinfeld[7] warns that over-legislation in an attempt to accomplish the mythical goal of universal safety may regulate out of existence most old cosmetics; and perhaps no new ones will appear.

The harvest of such a program will be an increase in the cost of cosmetics and the loss of the small business enterprise from the economy. Do not underestimate the importance of cosmetics and toiletries in our society. There is comfort, well-being, satisfaction, and confidence bestowed on millions of men and women daily by the commodities developed in the cosmetic laboratories. The physician who fails to include cosmetics in his armamentarium along with the active dermatologicals, mood-energizers, corrective surgery, physiotherapy, and the like is practicing his art with shameful neglect. A large hospital in metropolitan New York is shortening the hospitalization time and disability of depressed female patients by a successful program involving these women in personal hair-grooming activities.

Through the years the cosmetic chemist has by actual experience developed a large inventory of safe preparations; yet there is no provision in the proposed law[7] to utilize this knowledge. The law, however, seems to assume a particularly ungraceful posture in elaborating that a cosmetic will be deemed unsafe not only if its intended use is shown by tests to be harmful, but also if any reasonable forseeable use (e.g., ingestion) should be so as well! A kind of reverse double jeopardy reminiscent of the legislator who was in a distant city when he received word of the death of his mother-in-law. The poor fellow had been constantly flailed by this woman's acid tongue and irritating manner. The news-bearing cablegram also requested, "Wire instructions, shall we bury or cremate?" The legislator immediately cabled back, "Take no chances, do both." Could this be the thought process which fashioned the cosmetic regulations?

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945 Zerega Avenue

STATE ACTIVITIES

Testing for Phenylketonuria

Enactment of 1964 Assembly Bill No. 520 (Chapter 268, P.L. 1964) declares it to be the policy of New Jersey that every newborn child be tested for phenylketonuria. The State Department of Health is moving to make the test applicable to as many newborn children as possible with the funds available. If tests indicate that PKU may be present, there is still need for a more definitive diagnosis. Then treatment will be initiated and arrangements made for a periodic determination of the phenylalanine level in the blood.

These services are provided at two places in our state: the Bancroft Diagnostic and Evaluation Clinic, 437 East Kings Highway, Haddonfield (Area Code 609-429-0961). The pediatrician in charge is Dr. Warren D. Grover. These services are also provided at the PKU Clinic, Babies Hospital, Newark (Area Code 201-482-6200).

The Maternal and Child Health Program of the State Department of Health assists in helping pay for these services for families who are unable to assume the cost.

You Are Now in Social Security

Self-employed physicians are now under Social Security, retroactive to January 1, 1965. You will be required to pay next April $259 in Social Security taxes for this year. The tax will go up to $406 for 1966 and rise over the years to $515 by 1987. Physicians were the last profession to be covered by Social Security and the only group to be forced into the system over the protests of its professional organization.

THE BEST GRADUATE PROGRAM OF 1965

What will surely be the best graduate medical program of 1965 is just on the other side of the Delaware. This is the comprehensive scientific program, new graduate courses and special clinical workshops, all being featured at the American Medical Association's Clinical Convention, November 28 to December 1 in Philadelphia. Topics to be covered include: ulcerative colitis, gram-negative bacterial infections, a medical-surgical review of cardiovascular surgery, drug therapy in rheumatology, and cancer chemotherapy and preventive surgery.

You will be able to participate in one of the convention's new features. Clinical workshops on diabetes, examination of the heart, management of common eye problems, and the solution of selected diagnostic and therapeutic problems will be conducted by outstanding teachers.

Also new will be a course in cardiovascular therapeutics. And to be repeated will be the popular and previously oversubscribed course in gynecology and obstetrics first offered at the clinical convention last year in Miami.

An unusual conference on the Medical Aspects of Sports will be held on November 28 in the Benjamin Franklin Hotel. It will be of special interest to high school and college team physicians.

Color television will be presented on "Lymphocytes, Cellular Immunities and Tissue Transplantation," "Renal Hypertension," "Pulmonary Resection," "Pulmonary Function Studies," "Surgical Aspects of Thyroid Diseases," and "Medical Aspects of Thyroid Diseases."

Twelve "fireside conferences" will be held Sunday evening, November 28, at the Warwick Hotel. They will be joint sessions of the American College of Chest Physicians and the AMA.

MEDICARE IN BASIC ENGLISH

BASIC PROGRAM

Hospitalization

Up to 90 days in each "spell of illness." The patient pays the first $40 of hospital costs. If he stays more than 60 days, he pays $10 for each additional day up to the 90-day limit. A "spell of illness" starts with the first day of hospitalization and ends when the patient has spent 60 consecutive days without hospital or nursing care. He may still be sick and disabled, but the "spell" is over.

The hospitalization covers room and board, prescribed drugs while hospitalized, and other services and supplies except private duty nursing and except the services of physicians (other than interns or residents in training). Christian Science sanatoriums and psychiatric hospitals are included, but there is a lifetime limit of 190 days in a psychiatric hospital.

Nursing Home Care

Up to 100 days in an extended care facility* in each "spell of illness" after a stay of at least three days in a hospital. There is no charge to the patient for the first 20 days. The patient pays $5 for each day above 20, up to the 100-day limit.

Home Nursing

Up to 100 visits by nurses or technicians in a one-year period following the patient's discharge from a hospital or nursing home. The services furnished must be in accordance with a program set up and periodically reviewed by a physician.

Diagnostic Services

Tests and related diagnostic services (except those done by physicians) that are "normally" provided by hospitals to out-patients. The patient pays $20 of the charge for *each* diagnostic study provided by the hospital in a 20-day period. The patient pays 20 per cent of the charges above $20.

SUPPLEMENTARY PROGRAM

Persons enrolling in this program will pay $3 a month in premiums. The federal government will match this with another $3 a month. The federal share will come from general tax revenues. This covers most other major medical expenses except dental services and drugs.

A participant in the program pays $50 of his annual costs for the services and supplies covered. He also pays 20 per cent of the annual costs above $50, while the program pays 80 per cent.

The coverage includes: (1) physicians' services (including surgery) whether done in a hospital, clinic, office, or home.

(2) Up to 100 home nursing visits each year in addition to those allowed under the primary program and without any requirement for prior hospitalization.

(3) Various services and supplies (in or out of a medical institution) such as x-ray and other diagnostic tests, radiologic treatments, surgical dressings, splints, casts, iron lungs, and other specified prosthetic devices including artificial arms, legs and eyes, and ambulance service.

WELFARE AID

The bill authorizes increases of about $400 million a year in federal grants for public assistance and other welfare programs. It consolidates the Kerr-Mills medical assistance benefits with five related programs and sets federal standards for scope and eligibility. There is now a new program of care for children in impoverished families, with $185 million in grants authorized for the first five years. Grants for maternal and child health services and aid to crippled children are raised from $80 million to $120 million in 1970.

By revising the general formula for public assistance grants, the bill raises annual federal authorizations by $150 million.

* *Translation:* Nursing Home.

Participants in the ceremonies Honoring Dr. Newell



Dr. Fred B. Rogers, Archivist to our Society; Gertrude Ederle (see text); K. H. Creveling, Director of our State's Division of Resource Development; Mary Anna Duncan of Florida ("Miss Florida World"); Peter J. Guthorn, M.D., Historian of Dr. Newell's county medical society (Monmouth); and Robert Finkernagel of Cape Coral, Florida, representative of the Garden of Patriots, an organization of citizens to honor Americans who have performed outstanding acts of service and whose accomplishments have not been properly recognized.

Dr. Newell: The Member Who Became Govenor

To physicians in New Jersey, William August Newell of Allentown, New Jersey, was important because he was a pioneer practitioner, physician to Abraham Lincoln's family, and an exemplar of all that is noble in America's medical heritage. To civic leaders, Dr. Newell is important as the Governor of New Jersey during its critical pre-Civil War years. (He was Governor from 1857 to 1860.) To mariners, he is hailed as the founder of the country's "Life Saving Service at Sea." All in all, William A. Newell was a man of many parts, a man for all occasions.

And on August 14, 1965, his accomplishments were accoladed at Sandy Hook. Some of the participants in that ceremony are shown in this picture. The man at the left is Fred B. Rogers, M.D., archivist to our Society. And can you identify the woman on *his* left, one of Highlands best known citizens?* (If you were born after 1910, you can't.) The man in white is Dr. Peter J. Guthorn, historian of the Monmouth County Medical Society, Dr. Newell's own organization.

A plaque honoring Dr. Newell was presented as part of the *History Happened Here* awards program of the "Garden of the Patriots." The Garden, at Cape Coral, Florida, honors patriots who have performed outstanding service to America and who are deserving of wider recognition.

August 15 was an anniversary date in Dr. Newell's career. On that day in 1848 he realized the culmination of his long-time efforts to obtain a federal appropriation for the start of the life saving service in America. The first $10,000 grant was to set up stations on the New Jersey coast from Sandy Hook to Little Egg Harbor. These were to be manned by volunteers.

* She is Gertrude Ederle, now of Highlands, New Jersey, the first American to swim the English channel. That was in 1926. She prepared for this in the water off Highlands, New Jersey, and Sandy Hook.

Dr. Newell's concern for the saving of lives at sea resulted from his residence with an uncle, Dr. G. Augustus Hankinson of Manahawkin, N.J. There and on nearby Long Beach Island he saw the results of ship wrecks off the Jersey coast and conceived a plan for tossing a weighted rope to a foundering ship and using the rope as pulley to carry a "cradle" to the deck to convey passengers and crew back to shore.

The site of the ceremony, Twin Lights, overlooking Sandy Hook State Park, was deeded to New Jersey by the Borough of Highlands. It is administered by the New Jersey Department of Conservation and Economic Development as an historic museum. The lighthouse dates back to 1826 and is on the highest elevation on the New Jersey coast. The light towers thrust an additional 50 feet into the air.

The "twin" towers were first lighted in 1828. One of the lights, with a force of 9,000,000 candle power, was considered the most powerful beacon in the United States. The lights burned continuously from 1862 to 1905! A light in the north tower is still operated from April 15 to November 15 each year by the Department of Conservation under an agreement with the United States Coast Guard.

Here is the text of the plaque:

HISTORY HAPPENED HERE
LET ALL WHO READ THIS REMEMBER

William Augustus Newell (1817-1901), Father of the U.S. Life Saving Service, noted physician, U.S. Congressman, and Governor of New Jersey 1857-1860.

Seeing hundreds of people die in ship wrecks on the New Jersey coast with no help available, Dr. Newell began the good fight for a U.S. Life Saving Service. He succeeded, and this Service is now part of the U.S. Coast Guard. On August 14, 1848, James K. Polk, President of the United States, signed the resolution.

"Providing surf boards, rockets, carronades, and other necessary apparatus for the better preservation of life and property from ship wrecks on the coast of New Jersey between Sandy Hook and Little Egg Harbor."

Presented August 15, 1965 by the Garden of Patriots at Cape Coral, Florida.

The ceremony was conducted by Robert Finkernagel of Cape Coral, representative of the Garden of the Patriots. Captain Charles E. MacDowell of the Coast Guard spoke on the history of the lifesaving service in the United States. Dr. Fred B. Rogers, archivist of The Medical Society of New Jersey, reviewed Dr. Newell's role in medicine and his pioneering in the skin graft operation for restoring eyelids.

The scroll and certificate for the plaque honoring Dr. Newell was accepted for Governor Hughes by Kenneth H. Creveling, Director of the Division of Resource Development.

Blue Shield Benefits Extended

Blue Shield announces that benefits under its Basic and Student Programs are being expanded with no increase in the subscription rate. The Plan, for the most part, is operating under rates that have been in effect since May 1961, when it received its only rate increase in 23 years without a corresponding increase in benefits.

Over 2 million of the Plan's 2.5 million members will receive the additional coverage. Not affected are groups enrolled under national account agreements or other special programs which are experience-rated, or individuals enrolled under the special low rate Senior Citizen Program. Dr. Alfano explained that the Plan is "making adjustments in some of our payments to physicians. The Trustees have developed revisions which will bring Medical-Surgical Plan benefits more in line with today's medical economy as well as with the payments made by neighboring Blue Shield Plans."

One new benefit will now allow payment for inhospital care of a healthy newborn infant by a doctor other than the physician who delivered the baby. Heretofore coverage for such care was included in the obstetrical fee. Coverage of surgical services by dentists also has been expanded. It now includes inhospital extraction of bony impacted teeth (heretofore an

ineligible service), dental surgical services for accidental injury during the hospital admission for the accident and in-hospital treatment of malignancy of the mouth.

Blue Shield has been paying for certain surgical services performed by dentists in hospitals since last year, and no extra premium has been charged for this.

Benefits have been increased for emergency surgery in a doctor's office for accidental injury. A payment ceiling of $50 for such services has been lifted. Now the same payment will be made as when the procedure is done in a hospital.

All of the additional benefits (with the exception of care of the newborn) are provided in the attractive Student Program coverage, now available at reduced rate to full-time students at institutions of higher education.

A new category of "Intensive Medical Care" replaces current augmented payments for the initial 3 days of "Critical Care" and allows increased payments for up to 14 days for certain specified acute diagnoses. The fees are up to $30 for the first day, $20 for the second day, and $10 per day thereafter through the 14th day. Consultations for a number of specified diagnoses (or others which required a complete history and complete physical examination) will be paid $30. Other consultations will be paid $20.

Maximum allowances for medical care have been increased for the initial two days of an admission to $15 and $10; the third through the 14th day will be paid up to $6 per day; and from the fifteenth day on, the fee will be up to $5 per day.

Increases in fees, ranging from $5 to $150, have been made for more than 300 surgical procedures, mostly the more complicated ones; decreases ranging from $5 to $40 have been made for about 50 procedures in which the Plan's allowances were found to be higher than those of neighboring fee schedules.

The Schedule's maximum allowance for one procedure has been increased from $350 to $500. The ceiling of $450 for all procedures by one physician during one admission has been raised to $600. The overall limitation of $800 for all multiple major procedures in an admission of over 90 days has been increased to $1,000, and that may be exceeded in special cases by approval of the Board of Trustees.

The Open Heart Surgery "package" providing benefits for the services of the operating team has been increased from a total of $1,000 to $1,200.

The new Certificates stipulate that payments for services rendered by non-participating physicians *will be made to subscribers, and are not assignable.* Participating Physicians will, of course, continue to be paid directly by the Plan.

OBITUARY

Dr. Alvin E. Cortese

One of Passaic County's pioneer otolaryngologists ended a distinguished career on August 12, 1965. Born in 1899, he received his M.D. degree at Temple in 1929. He interned at the Paterson General Hospital, and then did graduate work in his chosen specialty at the Polyclinic Hospital in New York. He was invited then to join the associate staff of that hospital, and he served in its wards, clinics, and operating room for many years prior to his retirement from practice in 1955. He was active in civic affairs in the Paterson area and served for several years as president of the Italian Circle of Paterson. A World War I veteran, he took part in many Legion activities.

BICENTENNALIA

A Latin Inaugural by Dr. William Burnet, 1767:

De usu scalpelli in pleurisis.

In his *History of Medicine in New Jersey,* writing about Dr. William Burnet (second president of The Medical Society of New Jersey), Dr. Stephen Wickes tells us that "being a fine classical scholar, on assuming the office on the first occasion he read an essay in Latin on the use of the lancet in pleurisy."

William Burnet, one of the organizers of our state society, was a son of Dr. Ichabod Burnet (1684-1774) of Elizabeth. Born in 1730, William graduated from the College of New Jersey (Princeton) in 1749, studied medicine with Dr. Staats of New York, and settled in Newark as a physician. In 1766 he became one of the original members of The Medical Society of New Jersey, and in the following year was elected its president upon the death of Dr. Robert McKean.

Dr. Burnet took an active part in the struggle for independence. He was named first Judge of the Essex County Court under the State constitution. In 1776 he organized a force of 300 men for military service and was commissioned surgeon to the Second Essex Regiment. During 1780 and 1781 he served as a member of the Continental Congress, resigning to become Chief Physician and Surgeon of the Hospital Department of the Eastern District of General Washington's army.

After the war, Dr. Burnet continued his professional pursuits. His home was situated near the present Lincoln Park, Newark. He was appointed a Judge in the Court of Common Pleas. In 1786 he was re-elected president of The Medical Society of New Jersey. His address on retiring from that office in the following year was entitled, "The Nature and Importance of the Healing Art." It was later published in the Society's printed *Transactions* (1875).

A member of the First Presbyterian Church of Newark for the last twenty-three years of his life, he was one of its ruling elders. His wife, née Mary Camp, bore him a large family whose descendents continue to this day. Dr. William Burnet died on October 7, 1791, at age 61. One of his sons, Dr. William Burnet, Jr. (1754-1799), practiced in Belleville and served like his father as a surgeon in the Continental Army during the Revolutionary War.

Fred B. Rogers, M.D.

Burlington County Medical Society*

A horse race in 1828 was followed by a suit to recover a doctor's fee. And this led to the founding of the Burlington County Medical Society. How? Well, it appeared that the plaintiff doctor's medical license was unrecorded and this led to a further inquiry into the control of medical license. As our State was entering the 19th century, the law regulating the practice of "physic and surgery" required that a license should be obtained from the State Medical Society—whether the applicants had diplomas from Medical Schools or not—and imposed a $25 penalty for every prescription given by a non-licentiate. It further stipulated that unless the license was properly recorded (either in the office of the county clerk or with the Chief Justice), no fees for professional services could be legally demanded.

In 1828 the incident which led to the union

* Prepared by Mrs. Ruth E. Bunning, Executive Secretary.

(in 1829) of the new physicians then practicing in Burlington County was a horse race. Our scene takes place in the little town of Columbus, at that time known as Black Horse. The parties concerned were Dr. Asahel Page and Prince Murat, a relative of Joseph Bonaparte, ex-king of Spain, then residing at his beautiful house in Bordentown.

The prince and the doctor were both fond of horses, and each kept several for racing. They were to have a race through the street of Columbus. This had been well advertised. The prize was to be one of the racers. The prince and the doctor appeared in due time and the race was run "in the presence of a goodly crowd."

The prince came off the winner and demanded his prize. The doctor claimed there had been foul play and refused to surrender his steed. The prince declared in a menacing manner that he would not pay the doctor's bill for professional services he had rendered earlier.

Suit was brought by the doctor to recover the amount of his bill. The case was tried and the doctor was nonsuited—the evidence showing that (although he had passed an examination and had received a medical license) he had neglected to comply with the law which required the filing of his certificate with the county clerk or Chief Justice. Hence the loss of his suit.

The story of this horse race and trial created considerable excitement. The discovery was made that there were but few authorized medical licentiates in Burlington County—Dr. Nathan W. Cole of Burlington and Dr. John L. Stratton of Mounty Holly were two of that number. However, there were three young men fresh from the University of Pennsylvania with their diplomas who took advantage of the occasion and went to Freehold to pass the examination before the censors. Having passed, certificates were furnished and they were legally registered; they were Doctors Charles Ellis of Burlington, Benjamin H. Stratton of Mount Holly, and John C. Davis of Pemberton.

These three young men along with the two senior physicians constituted the legal number for forming a district medical society, and on April 30, 1829 they met at the house of Griffith Owen in Mount Holly to organize.

At this meeting they agreed to ask the State Society for authority to organize according to law. In New Brunswick on May 12th, at the annual meeting of The Medical Society of New Jersey, such authority was granted. On May 19th these five physicians took preliminary steps necessary to effect their organization. They named Doctors Benjamin Stratton, Charles Ellis, and John Davis to draft regulations for their government. On the third Tuesday in June, they adopted their Constitution, designating their union as "The District Medical Society of the County of Burlington." Officers were: Dr. Nathan W. Cole, President; Dr. Charles Ellis, Secretary; and Dr. John L. Stratton, Treasurer. Charter members were these physicians, plus Dr. Benjamin Stratton and Dr. John Davis.

The new Constitution and By-laws called for four meetings each year, with three members constituting a quorum. Annual dues were $1 per member with a $2 fee upon joining the Society. The dues which the County Society paid to the State Society were $4 per year. The fine feathery script of the old books of the Society sets forth many other provisions which are still in effect.

Founding of the Camden County Medical Society*

The Camden County Medical Society was an outgrowth of the old Gloucester Society. Old Gloucester County originally included Salem and Burlington. It extended from the Dela-

* Prepared by H. D. Barnshaw, M.D., historian to this county society, this review is drawn largely from Godfrey's "History of the Medical Profession of Camden County."

ware River to the Atlantic Ocean. In 1766, The Medical Society of New Jersey was established and among its original members was Dr. Isaac Harris, father of Dr. Samuel Harris, who was the pioneer physician of Camden. In 1818 the Gloucester District Society was organized with the following members: Dayton Lummis; Thomas Hendry; Joseph Fithian; Lorenzo F. Fisler; Davis Evans; Francis Hoover; William Hunt; Samuel Harris; Bowman Hendry; J. J. Foster; Ezra Balear; and John C. Warner. This organization continued until 1821, when it lapsed. It started anew in 1835 with only five members: C. V. Clark; Isaac S. Mulford; Thomas Lee; Joseph Fithian; and Samuel Harris. This 1835 society was not recognized by The Medical Society of New Jersey because they had failed to file their constitution and bylaws. In 1846, after the separation of Camden County, the Gloucester Society was once more reorganized.

A petition for the establishment of a District Medical Society of Camden County was presented to the State Society at New Brunswick on May 12, 1846. A "commission" was ordered by the Society authorizing Doctors Jacob P. Thornton and Charles D. Hendry of Haddonfield, Isaac S. Mulford and Richard M. Cooper of Camden, and James S. Risley of Berlin to organize at Haddonfield. On August 14, 1846, a meeting was held in Haddonfield. Here the "District Medical Society for the County of Camden in the State of New Jersey" was organized. The original members present were Doctors Jacob P. Thornton and Richard M. Cooper, graduates of the University of Pennsylvania, 1828 and 1839 respectively; James S. Risley, Jefferson Medical College, 1844; Charles D. Hendry and Othniel H. Taylor, University of Pennsylvania, 1833 and 1825 respectively, making the legal number required to effect an organization. Dr. Isaac S. Mulford, an alumnus of the University of Pennsylvania, 1822, was unable to attend on account of sickness but was present at the following meeting. Dr. James S. Risley was elected president; Dr. Othniel H. Taylor, vice-president; Dr. Richard M. Cooper, secretary, and Dr. Jacob P. Thornton, treasurer.

A doctor of Camden County who typified the "true physician" was Dr. Bowman Hendry who practiced at Haddonfield from 1794 to 1838. He had been educated at the Woodbury Academy and at the University of Pennsylvania. Even in boyhood he was distinguished for his courtesy and kindness of disposition; and, as a student, for his punctuality, industry, and zeal. This won for him the confidence and favor of his teachers. Towards the close of his course in study at the University of Pennsylvania, the "Whiskey Insurrection" broke out in Pennsylvania (1794) and young Hendry entered the government service as a private soldier. Passing an examination in medicine, he was commissioned as assistant surgeon. He opened his office in Haddonfield, but his practice soon extended from the Delaware to the Sea. He did more to elevate the standard of medicine and to rescue obstetrics from the hands of midwives than any other physician of his time. For fifteen years, Dr. Hendry rode the saddle and was often absent days at a time on his professional visits. Not infrequently, because of the extent of his journeys, he was obliged to sleep in the woods. He wore out more than two hundred horses in his service. During the latter part of his career, his barn and horses were burned, but so great was his popularity that his friends immediately erected and presented new buildings to him and replaced his horses. Dr. Hendry lived in the area that is now Camden County. He was a distinguished physician and devoted to his profession, and the members of the society are proud that he was numbered among us.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

BICENTENNIAL CELEBRATION

Annual Meeting

Friday-Wednesday

May 14-18, 1966

Haddon Hall, Atlantic City

PLAN TO ATTEND

ANNOUNCEMENTS

Meeting on Colposcopy

November 6 and 7 of this year have been selected as the dates for the annual meeting of the American Society for Colposcopy and Colpomicroscopy. For details, write to Fritz K. Beller, M.D., New York University School of Medicine, 550 First Avenue, New York 16, New York.

Conference on Hodgkins Disease

On Monday, November 22, 1965 an all-day seminar on Hodgkins Disease will be held at the Hilton Hotel at 401 Seventh Avenue in New York City. Sponsored jointly by the American Cancer Society and the National Cancer Institute, the meeting will focus on clinical aspects of the recognition and management of Hodgkins Disease. The morning session starts at 9:30 a.m. and the afternoon seminar is scheduled for 2 p.m. The morning meeting will spotlight diagnosis and pathology; the afternoon meeting will concentrate on treatment and management. There is no registration fee. For details, write to Dr. Jack Milder, American Cancer Society, 219 East 42 Street New York, N.Y. 10017.

Cardiology Day

The American College of Physicians is holding an all-afternoon meeting on November 10 at the Princeton Inn in Princeton under the general title, "Advances in Cardiac Management." Many phases of this practice will be covered. Papers will be given by a faculty of outstanding experts. For details, write to Dr. James F. Gleason, 7 South Oxford Avenue, Ventnor City, New Jersey 08406.

Ophthalmology Courses Available

A full-time five day course in basic ophthalmology will be given December 6 to 10, 1965. Tuition is $175. For registration, and details, write to Institute of Ophthalmology, New York Eye & Ear Infirmary, 218 Second Avenue, New York, N.Y. 10003.

Medical Study Cruise in January

Albany Medical College will put on a 10-day cruise, starting January 28, 1966, on the luxury vessel *Brasil*. The seminar on board will cover several fields of medicine, and substantial AAGP credit is allowed. The cruise calls at Puerto Rico, Virgin Islands, and Barbados. For more details, write to the Department of Postgraduate Medicine, Albany Medical College of Union University, Albany, N.Y. 12208.

Course in Pediatric Allergy

A 2-day course in pediatric allergy will be given in Philadelphia on November 3 and 4. The program is scheduled for the Children's Hospital in that city. The AAGP offers credit for attendance at this symposium. For more details, write to Dr. Leonard Girsh at 3701 North Broad Street, Philadelphia 19140.

Fractures of the Face and Orbit

Reserve Wednesday afternoon, December 1, 1965 for a meeting in Princeton, sponsored by the Academy of Ophthalmology and Otolaryngology of New Jersey. *The topic:* Fractures of the Face and Orbit and Management of Eye Injuries. *The time:* 3 p.m. *The principal speaker:* Thomas D. Reese, M.D., Associate Professor of Plastic Surgery at the New York University, College of Medicine. *The place:* The Princeton Inn. You are invited.

Erratum

On page 391 of the August 1965 issue of this JOURNAL appeared a paper by V. W. Grossier on "Advances in the Diagnosis of Gastric Lesions." Through error, no acknowledgement was made of the splendid support given by the New Jersey Health Department and its Commissioner, Dr. Roscoe P. Kandle. The author wishes to correct this omission by acknowledging with deep gratitude this support and informing readers that the study was made possible, in part, by a grant from the Division of Chronic Illness Control of our State's Department of Health.

BOOK REVIEWS

Experiences in Renal Transplantation. Thomas E. Starzl, Ph.D., M.D. Philadelphia, 1964, Saunders. Pp. 383, illustrated. ($17.00)

To the small and select group of research workers engaged in renal and/or other organ transplantation, this book will be of great value if for no other reason than that it brings together in compact, readable form a concise summary of the experiences already gained in this exciting field. This text should be available to anyone who is planning to initiate a program of organ transplantation or who plans to participate in such a program. This includes not only the surgical team, but also the members of the ancillary groups who will be involved, such as immunologists, bacteriologists and pathologists. A study of every chapter of this book will be invaluable in setting up these programs. The author and his collaborators spell out plainly all the minutiae of teamwork, expense, and technical proficiency that will be required. A previously well-organized and smoothly functioning renal dialysis team, with all necessary equipment and laboratory facilities, is extremely important. This is not the type of surgery that can be learned in the clinical surgical amphitheater. The technical proficiency required is attained only by hours and days of laborious work in the surgical laboratory, with animal experimentation. The text includes a discussion relative to the goals of future research and the moral, philosophical, technical aspects involved. Also reviewed is the problem of the availability of donors, of homo versus hetero transplantation, and of the possible utilization of cadavers. The description of the actual surgical procedures involved is clear and concise; and the illustrations are admirable.

This book will be valuable to physicians and surgeons, and to the growing body of intelligent laymen who like to keep abreast of current scientific achievements. The general, non-specialist reader will find a good over-all presentation of the entire problem of organ transplantation. The specialist will here find a book so arranged that he can concentrate on those aspects of the problem of most interest to him.

One notable omission is a discussion of the medicolegal aspects of the problem. A new chapter in medical jurisprudence will have to be evolved to cover the complexities of this new facet of the healing arts. And, while not mentioned specifically, the topic under discussion carries with it extremely important considerations concerning possible future changes in the entire concept of medical care, such as the growing importance of team work and the knotty problem of a fair distribution of the tremendous financial burden involved in bringing the fruits of the investigative laboratory to bear on the problem of treating the individual patient. This book deserves careful study.

ROBERT E. FULLILOVE, JR., M.D.

Scintillation Scanning in Clinical Medicine. James L. Quinn, III, M.D., Editor. Philadelphia, 1964, Saunders. Pp. 278, illustrated. ($11.50)

Much of what is written in medicine is of a transitory nature, since a book reports what has been accomplished up to the time of the report and indicates the problems which still exist and are being investigated. This text falls into such a classification. It is the result of a symposium held in January 1964 at the Bowman Gray School of Medicine. The book explains the technical and mechanical media which are available, points out their faults, and discusses the areas in which improvements are needed to increase scope and accuracy. The same is true of the radiopharmaceutical materials used as a source of emanation of the radioactive particles. Criteria for a good radiopharmaceutical are outlined clearly.

There are discussions of the status of scanning of various organs which include the thyroid, parathyroid, bone marrow, kidney, spleen, pancreas, lung, liver, myocardium, and heart pool. Much space is given to brain scanning.

While the book is frequently technical and obviously intended for specialists in nuclear medicine, it is valuable since it provides a ready reference when specific problems in diagnosis are being worked out.

ELLIOT RINZLER, M.D.

Conditioning Techniques in Clinical Practice And Research. Edited by Cyril M. Franks, Ph.D. New York, 1964, Springer. Pp. 328. ($8.50)

The book is offered as a corrective to the over-emphasis on the "Psychodynamic" approach to etiology, diagnosis, and treatment of psychiatric and allied disorders, since this has allegedly produced few positive findings. The editor states that there is no unequivocable evidence to show that the dynamic orientation is effective either therapeutically or in diagnosis. He adds that behavioral diagnosis and therapy are gaining prominence, and that conditioning is an important and promising approach. One author asserts that the conditioning technic is short and simple to administer, requires little cooperation; that it is objective, easy to quantify and record. It is applicable to almost all subjects at every age level. Significant experimental results are presented, showing that the conditioning technic is useful in the diagnosis of intracranial pathology in the absence of clinical symptoms. Also, there is evidence that patients can be conditioned to avoid certain types of seizures. There are suggestions that many states believed to be "neurotic" are, in fact, the end result of early conditioning; and that deconditioning is the therapeutic approach of preference.

RICHARD BENJAMIN, B.S.

Cellular Injury. Edited by A. V. S. de Reuck, M. Sc. and Julie Knight, B.A. Boston, 1964, Little, Brown and Company. Pp. 403, illustrated. ($12.00)

The volume "Cellular Injury" contains chapters written by a distinguished group of contributors. The text will be appreciated largely by those who have majored in biochemistry or biology; but it is of value in our Academy Library as a reference for practitioners interested in cell behavior under a large variety of conditions, including environmental factors, which cause the death of the cell. It is not feasible, in this brief review, to discuss all of the contributions. I have selected "The Death of Cells in Normal Multicellular Organisms" by J. D. Biggers as an example.

Dr. Biggers reminds us that cell death is an essential part of understanding disease processes. In most metazoan animals, the orderly death of cells is an essential phenomenon which plays a vital role in the embryo during organogenesis, and also in the physiology of the fully mature individual. Under mild adversity the cells are able to compensate and can recover, once the noxious influence is removed. Under severe circumstances the compensatory changes are

overcome by irreversible changes and the cell dies. It is a *sine qua non* that the cells die at some fixed time. Their undue persistence, in fact, is just as pathologic as the destruction of cells a long time before they should normally divide. Many types of teratologic abnormalities arise from failures of normal cell degeneration and death. Cell death appears in many forms, from autolysis (as in the genital ducts) to oversynthesis (as in keratinization). In many instances the basic problem concerns mechanisms of differentiation which lead to cell death, while in others it concerns the action of humoral substances which initiate and control processes which also end in cellular death.

It is the reviewer's opinion that the successful preservation of cells, tissues, and organs at low temperatures offers immediate possibilities in the study of the comparative aging of different parts of the body. "It opens up the ultimate possibility of inducing suspended animation of the whole body for indefinite periods." The idea of biostasis of the whole body, although somewhat macabre, holds nothing new in principle. This is woven into the fabric of countless human beliefs, legends, and stories, from the resurrection of the dead to the awakening of the Sleeping Beauty.

LYNDON A. PEER, M.D.

Preventive Medicine in World War II, Volume VII, Communicable Diseases Other than Malaria. Colonel John Boyd Coates, Jr., M.C., U.S.A., Ebbe Curtis Hoff, Ph.D., M.D., and Phebe M. Hoff, M.A. Washington, D.C., 1964, U.S. Government Printing Office. Pp. 370. ($4.25)

Never before has there been an extensive epidemiologic study of so many diseases as here offered. This distinguished collection is a great monument to the medical profession of the era of World War II.

The present volume deals with arthropod borne diseases other than malaria. It reviews encephalitis, yellow fever, dengue, rickettsial, parasitic and other viral diseases. The detailed analysis of each of these diseases as compared to the environment and experience with previous wars makes this an interesting historical document. It serves as a useful, ready reference to all phases of each communicable problem. For example, dengue fever affected 91,000 American soldiers in World War II, yet Drs. Sabin and McCoy discussed the control measures in each of the areas and their effectiveness, the research activities, including human volunteer studies, chemotherapeutic agents, viral interference and most important of all, proof of the existence of multiple immunologic types of dengue. Similar contributions are made by each of the authors in this collection. This volume, as well as all previous volumes in the series, should be incorporated into every library.

LEON G. SMITH, M.D.

This Is Your Heart. Manuel J. Rowen, M.D. Plainfield, 1964, Boise Printing Company. Distributed by the Union County Heart Association. Pp. 154. ($1.25)

This booklet, written by an Elizabeth internist and distributed by the Union County Heart Associaton, is a homey treatise on heart disease, written for the inquisitive and inquiring layman. Its form is that of the author sitting across the desk from his patient and chatting about the anatomy, physiology, pathology, and pathogenesis of vascular disease. Written in an informal style, it is sprinkled with diagramatic illustrations, graphs, and charts. The chapters are prefaced with aphorisms from literature and from the ancient medical greats. There are short case histories, a technic which always interests the laity.

This is a "Doctor Book." The many people interested in looking up their illness for clear explanation are not going to be disappointed. They will find here in sufficient detail the answers they need to know. They will enjoy the authors breezy style. Considering the interest in medical topics in popular magazines, the Union County Heart Association should find *This Is Your Heart* in great demand.

HARVEY E. NUSSBAUM, M.D.

Medical History in Philately. Gerhard J. Newerla, M.D. American Topical Association, 1964, Milwaukee, Wisconsin 53216. Pp. 144 with one illustration. ($6.00)

A book about postage stamps with only one illustration seems like a *tour de force*. And this brochure achieves it. Introductory orders will be accepted at $5 remitted to the publisher at 3302 North 50 Street, Milwaukee 53216. The booklet is offset-printed and is hard to read because of the monotony of the type sizes, the irregular right margins, and the tight way the type is packed in. The lack of an index reduces the value of the text to the serious philatelist. The catalogue lists, as far as possible, all stamps showing physicians (including hundreds of varieties of Chinese stamps showing Sun Yet Sen, who was an M.D.). It also catalogues stamps honoring W.H.O. events and medical congresses, relevant charity seals, and stamps issued to combat various diseases.

HENRY A. DAVIDSON, M.D.

Stereoscopic Manual of the Ocular Fundus in Local and Systemic Disease. Frederick C. Blodi, M.D., Lee Allen and Alson E. Braley, M.D. St. Louis, 1964, Mosby. Pp. 132 with 101 Illustrations and 105 Colored Stereoscopic Slides. ($32.50)

This book, with its beautiful and striking colored stereoscopic fundus views, is based on the exhibit of stereoscopic photographs at the 1963 American Academy of Ophthalmology and Otolaryngology meeting. The exhibit was, I recall, very popular and deservedly so!

Although many atlases of the fundus are available, this is the first stereoscopic one. The colored slides are divided into logical groups. There are brief, explicit descriptions of each view. Photomicrographs present the pathologic background of many of the views.

This handsome book is of obviously great value to the student and to the beginner in ophthalmology. The stereoscopic views are of great interest and value to the experienced practitioner, both for the sheer joy of looking at them as well as a source of review.

S. JEROME GREENFIELD, M.D.

New and Nonofficial Remedies. Evaluated by the AMA. Philadelphia, 1964, Lippincott. Pp. 862.

It is hard for the clinician to hack his way through the jungle of new drugs and new drug forms. Here NNR comes to his rescue. Each drug (introduced within the past five years) is evaluated by the AMA or its consultants. Generic and non-proprietary names are given, followed by the familiar proprietary designation. Also covered are actions, uses, contraindications, dosage forms, side-effects and precautions in administering. The contents are divided into 23 major sections (antihistaminics, cardiovascular agents, hormones, tranquilizers and the like), but a rich alphabetical index makes it possible to find any monograph very simply. Appended is a roster of drug manufacturers including their streets addresses. A metric system conversion table is also included. As it is every year, NNR is one of the most useful books in any doctor's library—or better, on his desk. It soon earns its keep.

ULYSSES M. FRANK, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

OCTOBER, 1965 • VOL. XXXVIII, NO. 8

ANTIBIOTIC PROPHYLAXIS IN ACUTE VIRAL RESPIRATORY DISEASES

Carefully controlled trials have not shown that antibiotics are effective in preventing bacterial complications in the common cold. Any unnecessary use of antibiotics should be avoided.

The common cold is everyone's disease and has caused a profusion of all kinds of nostrums. The great losses from morbidity and great cost of remedies, home and prescribed, necessitate critical evaluation of optimum therapy. Since recovery almost always occurs, evaluation of therapy is difficult.

Prophylactic antibiotics have often been recommended and used in these diseases to prevent bacterial complications. The word prophylaxis literally means prevention of or protection from disease. Prophylactic drugs may be given to prevent disease in a normal person or to prevent complications in a person who is ill. Antibiotic prophylaxis cannot be evaluated when bacterial complications already are present.

Antibiotic prophylaxis of acute respiratory disease is generally based on the hypothesis that viral infections lower the resistance of the host and allow the normal bacterial flora to cause infections.

Experience has shown that the risk of superinfection or the acquisition of a new organism is high with broad-spectrum antibiotics and not insignificant with penicillin. The concept that antibiotic prophylaxis will regularly suppress the normal flora has not been substantiated.

Since the effect of placebo on symptoms in acute respiratory diseases has been established by controlled studies, it is essential that therapy trials be double blind. Results with the drug under study should be compared with those of a placebo or with symptomatic treatment, and neither the patient nor the physician should know which patient receives which treatment.

Since even experienced clinicians may miss streptococcal disease and since streptococcal infections will respond to antibiotics, it is essential in these trials to exclude streptococcal disease.

Trials Reviewed

In a review of a number of controlled trials among children, adult volunteers, and military personnel, both in the United States and Great Britain, it was found that the use of antibiotics was not effective in preventing complications of measles, influenza, or the common cold when streptococcal disease was excluded.

In fact, neither continuous nor intermittent antibiotic prophylaxis has been shown to alter the clinical course or reduce the complication rate of these diseases.

It must be recognized that the type of population studied may have an effect on the outcome of the trial. For example, the results of trials on military personnel may have only limited application. Military populations are composed of essentially healthy young adults.

STARKEY D. DAVIS, M.D., and RALPH J. WEDGWOOD, M.D.; *American Journal of Diseases of Children*, June, 1965.

Many military bases have no place other than the hospital to care for mild illnesses. Consequently, military hospital patients may represent milder disease than that seen at a civilian hospital.

Civilian study populations may differ also. Only the more severe cases may be admitted to a hospital. Furthermore, many civilian hospital patients may have rheumatic heart disease, emphysema, bronchiectasis, or some other chronic disease.

Some British groups have reported beneficial results from antibiotic prophylaxis in groups of miners with pneumoconiosis, children with recurrent infections, and others.

These findings cannot be reconciled with those of well-controlled trials in which antibiotics were not found effective. Possibly a factor in the British trials is the prevalence of chronic bronchitis, in which prophylactic antibiotics have proved effective.

Defining Complications

Even in the face of certain reservations about some of these trials, it is apparent that prophylactic antibiotics will not alter the primary course of acute respiratory disease and will not prevent bacterial complications in healthy persons. Additional trials are needed in special groups such as children with congenital heart disease, pregnant women, and patients with chronic pulmonary diseases, since prophylactic antibiotics have not been thoroughly evaluated in these conditions.

A problem central to all these trials is the definition of a bacterial complication. The appearance of a new sign or symptom does not necessarily represent a complication and is not always an indication for antibiotics.

Pneumonia may be taken as an example of the problems of defining a complication. Influenza viruses can cause pulmonary infiltrates. Pneumococci are often cultured from sputum or pharyngeal swabs of normal persons. Thus, a sputum culture positive for pneumococci from a patient with influenza and a pulmonary infiltrate is not necessarily proof of a bacterial pneumonia. Perhaps the problem of proving bacterial pneumonia in patients with viral respiratory disease could be approached with frequent, quantitative bacterial counts of the sputum or by lung puncture.

The appearance of new signs or symptoms is not adequate proof of a bacterial complication of acute respiratory disease but is an indication for further examinations or tests.

Sometimes it is said that antibiotics may not help the patient but at least they will not hurt him. The use of antibiotics without reasonable indication is no more rational than the administration of digitalis to a patient without heart disease or morphine to a patient without pain. Antibiotics often cause harm. They are potent agents and should not be given frivolously .

As a guide to therapy, the following statements are now well substantiated:

1. The great majority of acute respiratory illnesses are not bacterial.
2. Antibiotics have no effect on the primary course of viral respiratory diseases and thus have no place in their primary treatment.
3. Prophylactic antibiotics have not been shown to prevent bacterial complications of acute respiratory disease and are not generally indicated.

The patient with measles or influenza with a pulmonary infiltrate is not a problem of prophylaxis but of differential diagnosis. Patients with a cough but without pulmonary infiltrate can usually be managed without antibiotics. The more seriously ill patients require careful evaluation and appropriate cultures. There is little disagreement about the use of antibiotics in the severely ill patient when bacterial pneumonia cannot be excluded.

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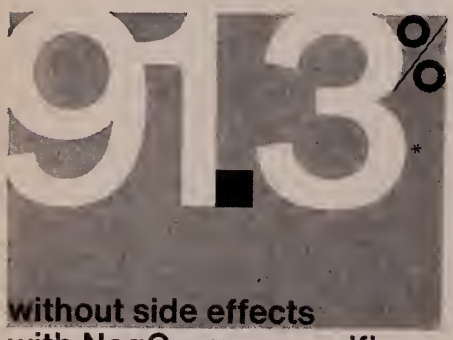
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References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

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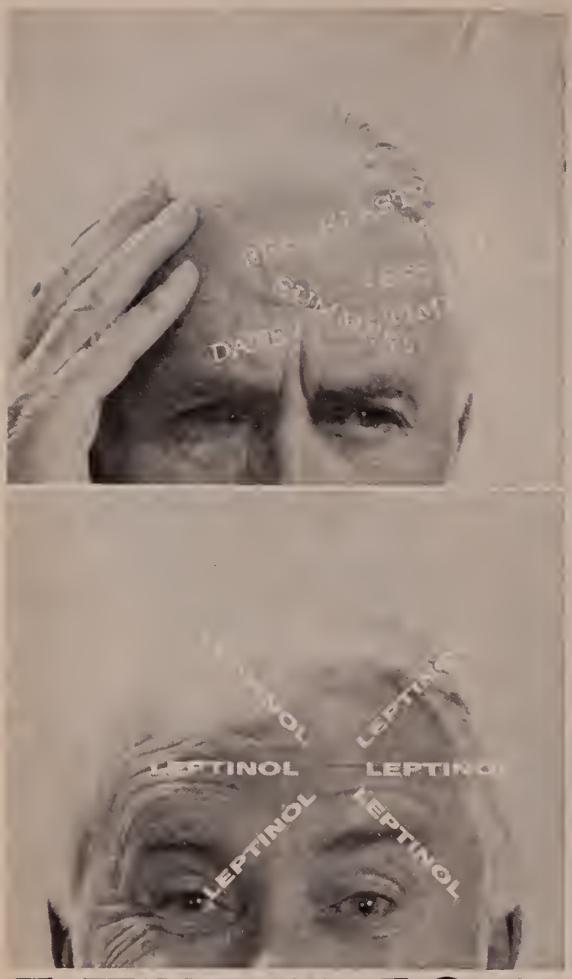
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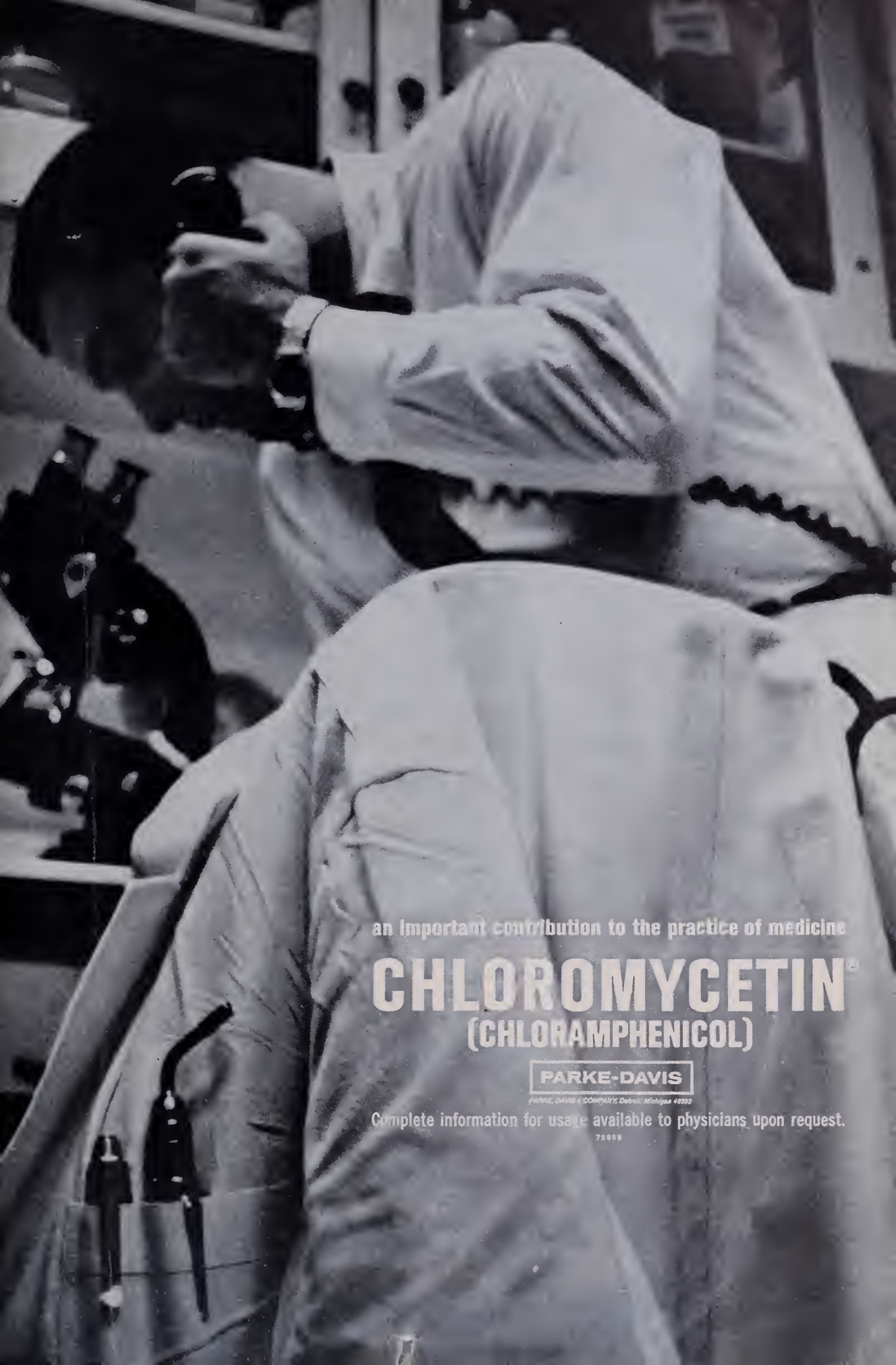
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Precordial pain as well as tachycardia, palpitation, breathlessness and faintness or arrhythmias are classic signs of cardiac disease. In many cases, however, they may represent a "somatic mask"—a psychophysiological equivalent of psychic tension.

Valium (diazepam) reduces the patient's disturbing psychic tension and helps improve such related symptoms as sadness and feelings of hopelessness, fatigue, insomnia, crying spells and nervousness.

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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal of hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."

Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959



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As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.

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Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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traindications
ma, danger of cardiac decompensation; ory or symptoms of peptic ulcer; renal, atic or cardiac damage; history of drug gy; history of blood dyscrasia. Because e increased possibility of toxic reac- s, the drug should not be given when the ent is senile, or when other potent chem- rapeutic agents are given concurrently. e doses of Butazolidin alka are con- dicated in patients with glaucoma.

autions
re prescribing, the physician should in a detailed history and perform a com- physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

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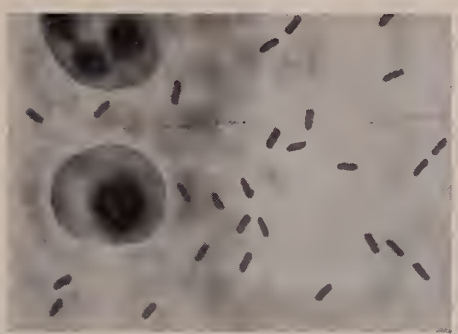
So, with the approval and support of The Medical Society of New Jersey, Medical-Surgical Plan has applied for consideration as carrier for the State of New Jersey under Part B of "Medicare."

Beyond that, we are aware of shortcomings in Part B that could result in considerable financial stress to the oldsters it is designed to help (but only up to a point). So we are considering a special program to "plug the holes" in Part B, that would make possible combined Blue Shield-government voluntary coverage of the scope enjoyed by other Blue Shield subscribers.

And last, we are advising our 65-and-over subscribers to *hold on to their Blue Shield coverage until July 1, at least.* Many mistakenly believe, because "Medicare" is now the law of the land, that they are already "covered for everything." May we suggest that doctors can do a good turn for their elderly patients by passing on the same advice.

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Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of 500 mg. for adults, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1,000. 250 mg. for children, available in bottles of 56 and 1,000.

References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016



following infection

STRESSCAPS B and C vitamins in therapeutic amounts...help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS.

STRESSCAPS®

Stress Formula Vitamins Lederle

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY Pearl River, N.Y. Lederle

2½-3 times more potent than papaverine with a longer duration of action

NON-NARCOTIC

SPACOLIN™

(Alverine citrate)

is a potent smooth muscle antispasmodic particularly effective in relieving spastic colon* and spasm of the biliary tract.

*"The diagnosis is based upon a history of catharsis or enema habit, dietary indiscretion or emotional strain, generalized or lower abdominal distress of the type described, abnormality of the bowel movement and tenderness along the course of the colon." *Cecil and Loeb, A Textbook of Medicine, Tenth Edition*

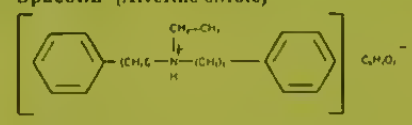


SPACOLIN™ *(Alverine citrate)*

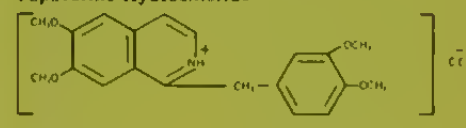
- A specific musculotropic counter-spasmodic.
- NOT an anticholinergic, therefore, has no atropine-like side effects.
- In man, its spasmolytic effect is two and one/half to three times stronger than papaverine with a longer duration of action.
- Neurotropic effect only 1/150 that of atropine.
- Has little or no effect on normal muscle tonicity and motility.
- Specific effect on the *sphincter of Oddi*.
- Mild local anesthetic effect and decreases gastric acidity.

The chemical structures of Spacolin, Papaverine and Atropine are as follows:

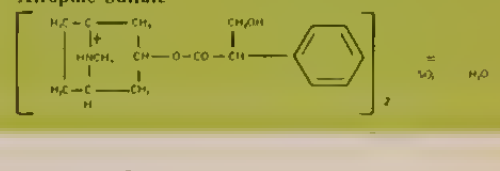
Spacolin (Alverine citrate)



Papaverine Hydrochloride



Atropine Sulfate



the interesting results *in vitro* and *in vivo* with

NON-NARCOTIC **SPACOLIN™ 120 mg. tablets**

(Alverine citrate)

the potent musculotropic counter-spasmodic 2½-3 times stronger than papaverine

IN LABORATORY

Studies with isolated tissue have furnished investigators with important information as to the qualitative and the quantitative activity of certain therapeutic agents. This technique consists of recording the motility of a segment of rabbit ileum suspended in Tyrodes solution at a constant temperature of 37.5° C. The movements of this smooth muscle strip are recorded on a kymograph. The rabbit ileal muscle is remarkably sensitive to spasm-producing drugs. Once a spasm has been initiated, additions of a very small quantity of a musculotropic agent produces an immediate relief of the spasm or relaxation of the muscle. The study of SPACOLIN along these lines indicated the following:

1. SPACOLIN has little or no effect on normal smooth muscle tonicity. The addition of Spacolin to a normal ileum muscle strip does not change the muscle tonus or contraction.

2. SPACOLIN is a musculotropic counter-spasmodic having an activity more than twice that of papaverine.

3. SPACOLIN is a weak neurotropic spasmolytic agent with an activity of approximately 1 150 that of atropine sulfate.







IN MAN

Double-Blind Study of a Spasmolytic Compound[1]

By ITALO EVANGELISTA, M.D.

Assistant in Medicine, Tufts University School of Medicine, Boston, Massachusetts, Medical Staff, Cambridge City Hospital, Cambridge, Massachusetts; Malden Hospital, Malden, Massachusetts; Whidden Memorial Hospital, Everett, Massachusetts.

RESULTS*	ACTIVE MEDICATION		PLACEBO	
Excellent	9	80%	1	25%
Good	11		5	
Fair	3	20%	7	75%
Poor	2		12	
TOTAL	25		25	

*Excellent — complete relief of symptoms during therapy.
Good — definite relief but still aware of symptoms periodically
Fair — symptoms reduced in intensity but still present
Poor — little or no therapeutic benefit.

"... a definite conclusion could be drawn from the study, namely, alverine citrate (Spacolin), is an excellent aid in the management of spastic gastrointestinal disorders."

(1) To be published

SPASM IS HELL



THE GATE OF HELL. — RODIN

SPACOLIN™* IS HELPFUL

(Alverine citrate)

*A SPECIFIC MUSCULOTROPIC COUNTER-SPASMODIC



NON-NARCOTIC

For fast relief of spasm

PRODUCT INFORMATION

Each tablet contains: Alverine citrate (Bis-gamma-phenylpropylethylamine citrate) ..... 120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in **spastic colon,** spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer†, cardiospasm, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations.

†Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, cardiospasm or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

SUPPLIED: Bottles of 100 and 500 — 120 mg. tablets.

PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
"First with the Retro-Steroids"



Because cerebrovascular insufficiency can be controlled

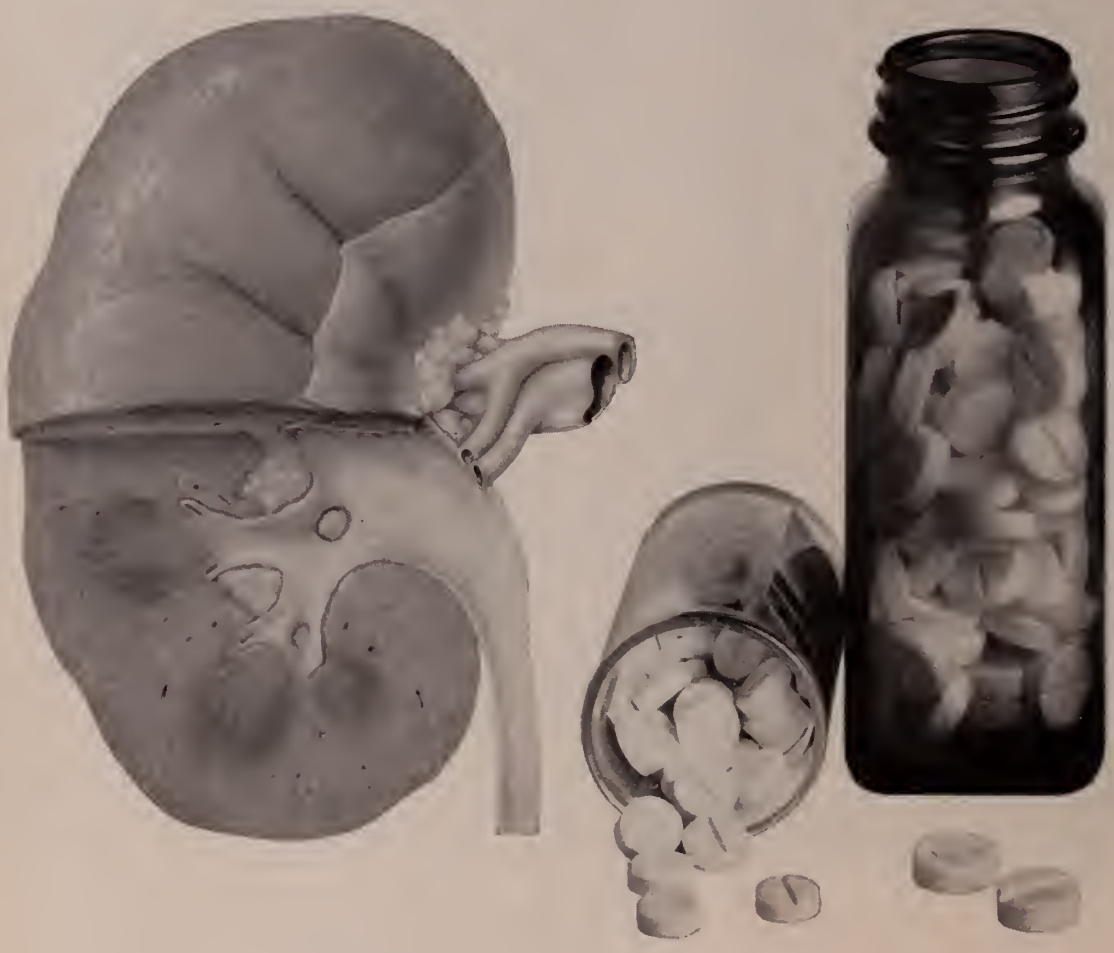
...help the older patient enjoy life with less confusion, defects in memory, dizziness, weakness, fatigue and decreased activity by maintaining the cerebral blood flow.

Precautions: Hydergine sublingual tablets have not been found to produce serious side effects even in doses far beyond the ones recommended. Some nasal stuffiness due to adrenergic blockade, transient nausea or gastric disturbances have been reported with high dosages.
Supplied: Hydergine Sublingual Tablets, 0.5 mg.; bottles of 100 and 1000.
Composition: Each sublingual tablet contains dihydroergocornine, dihydroergocristine, and dihydroergokryptine methanesulfonates (in equal parts), total 0.5 mg.

HYDERGINE®

SANDOZ

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

WALLACE LABORATORIES
Cranbury, N.J.

CM-5761



For predictability of action, purity, and uniform potency...

The original DIGITOXIN

DIGITALINE NATIVELLE®

Presented in a full range of convenient dose forms, all interchangeable by reason of total absorption.

For complete prescribing information
See package circular, P. D. R. or write:
Professional Service Division
E. Fougera & Company, Inc.

In asthma and emphysema, OPTIPHYLL
with its high absorption index attai
predictable, dependable therapeu
blood levels, thereby relieving the feeli
of "internal suffocation". Prolong
periods of remission and reduction in t
severity of attacks extend t
"atmosphere of freedc

The refreshing green mint flavor
OPTIPHYLLIN tends to assure patie
acceptability and to prevent drug fatig
Thus for efficacy and acceptability, it
a drug of first choice in the treatme
of asthmatic conditio

Indicated in the management of bronch
asthma, emphysema and other pulmona
disorders associated with bronchospas

PRODUCTS OF **NATIVELLE INC.** DISTRIBUTED BY **E. FOUGERA & CO., INC.**, HICKSVILLE, NEW YOF



Air for the asthmatic... in an atmosphere of freedom.

e (Calibrated dosage cup dispensed with each prescription)
5 ml. (1 tablespoonful) contains theophylline 80 mg., 20% alcohol.
dult dose in acute asthma attacks is 75 ml. of OPTIPHYLLIN,
ed theophylline in any form has not been given in the preceding
rs. A maintenance dose of 30 ml. of OPTIPHYLLIN can be initiated
hours later and maintained t.i.d. Maintenance doses in chronic
nary conditions associated with bronchospasm and in emphysema
om 45 ml. to 30 ml. t.i.d.
ediatric dose in acute asthma is 0.5 ml. per pound of body weight,
be repeated in less than 6 hours, and not more than 2 such dosages
given in 24 hours. Maintenance dosage varies from 0.3 ml. to 0.2 ml.
und of body weight t.i.d. until therapeutic effect is obtained.
HYLLIN is best absorbed on an empty stomach. *(Since nausea*
miting usually herald early signs of excessively high theophylline
levels, these manifestations should serve as early warning signs
uce or discontinue further administration of OPTIPHYLLIN.)
ffects and precautions. As with all theophylline preparations,
onal nausea, epigastric and substernal burning pain and rare
les of vomiting may be encountered. Other minor complaints are
itions, dizziness, nervousness and headache. Overdosage,
ularly in children, has led to severe vomiting, convulsions and
y. Theophylline should be given with caution in the presence of
ulcer and gout.

Opti phyllin™
theophylline elixir



See how much more acceptable this "cordial" green mint flavor can be...



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Hygroton®
brand of chlorthalidone

the longest-acting diuretic

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Dorhout Mees, E.J., and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York HY-3992 PC



good riddance

Hygroton, brand of chlorthalidone, gets rid of edema efficiently. Your edematous patients will generally need far fewer tablets than with most diuretics. And they'll generally save more on prescription costs. One tablet a day is a popular dosage. So is one tablet every other day. You may even find half a tablet three times a week does the job. No other diuretic works as long. And none has as much natruretic activity per tablet.* For good riddance of edema with the least number of tablets, prescribe Hygroton, brand of chlorthalidone.

Hygroton® brand of chlorthalidone

Geigy



**Happily,
not all your patients
are overweight**



**but
for those who are...**

Bamadex®

d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.)

Sequels®

Sustained Release Capsules

Most overweight patients could benefit from the appetite control provided by the prolonged anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action through the central stimulant effect of the amphetamine; tranquilizing action with only mild sedation through meprobamate; prolonged action through sustained release of active ingredients.

Contraindications: Hyperexcitable and prepsychotic states; patients hypersensitive to meprobamate.

Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

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6205



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective
GERIATRIC
antiarthritic
with

REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention... the enteric coating assures gastric tolerance... and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate-SF

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe
PABALATE-SODIUM FREE

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"My cooking agrees with everyone but me"

She complains about her upset stomach and blames her cooking...you diagnose functional G.I. disturbance and associated stress...as manifested by indigestion, heartburn, bloating, or constipation. Prescribe

DECHOLIN-BB®

(Hydrocholeretic·Antispasmodic·Sedative, AMES)

Each Tablet Contains:

BUTABARBITAL SODIUM .....15 mg (¼ gr)
(Warning: May be habit forming) to ease nervous tension

DEHYDROCHOLIC ACID .....250 mg (3¾ gr)
to produce a large volume of watery bile, hydrate the bowel contents and gently stimulate intestinal motility

BELLADONNA EXTRACT .....10 mg (⅙ gr)
to reduce smooth-muscle hypertonus

Average Adult Dose: 1, or if needed, 2 tablets three times daily. **Precautions:** Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction. Caution drivers against possible drowsiness. **Side Effects:** Dehydrocholic acid may cause transitory diarrhea; belladonna—blurred vision, dry mouth. **Contraindications:** Biliary tract obstruction, acute hepatitis, glaucoma, and prostatic hyperplasia.

72764

Available through your regular supplier: DECHOLIN-BB, bottles of 100 tablets.

Ames Company, Inc., Elkhart, Indiana AMES



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

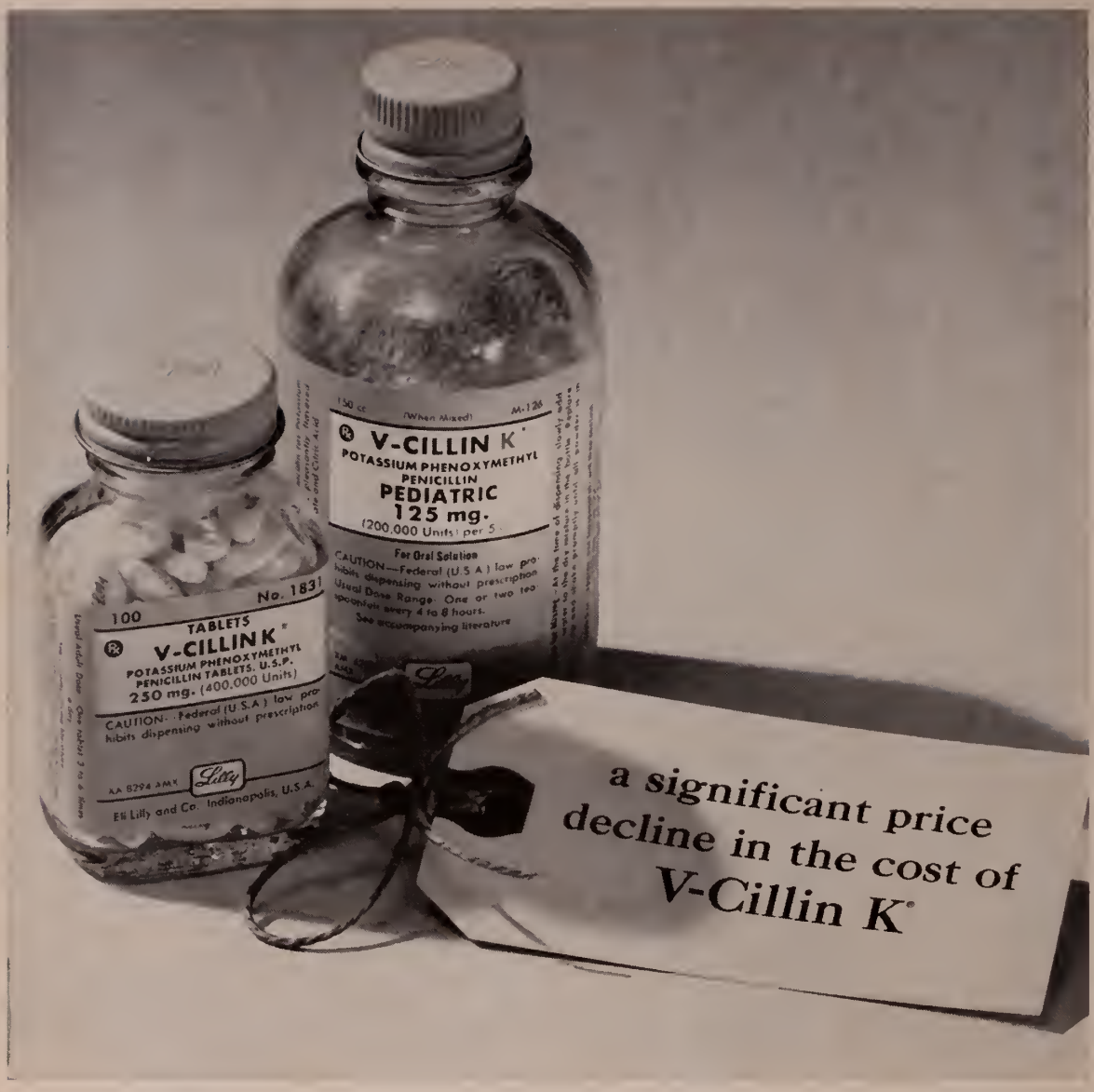
That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.





V-Cillin K now costs approximately 21 percent less. This significant price decline constitutes a substantial saving and still offers these important benefits over penicillin G:

The effectiveness of intramuscular penicillin. Just three 250-mg. doses daily provide total twenty-four-hour penicillin blood levels equal to those achieved by injection of 600,000 units of procaine penicillin G. A fourth dose increases daily penicillemia to levels 35 percent above those achieved by injection.

Consistent dependability—even in the presence of food. Comparative pharmacologic data show that V-Cillin K produces peak blood levels *twice* as high as those of penicillin G, with *half* the dose.

New, thin coating . . . new size and shape. The new coating eliminates the characteristically bitter taste of oral penicillin and makes V-Cillin K tablets easy to swallow. The new shape makes them easy for physicians and pharmacists to identify.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

V-Cillin K®

Potassium Phenoxymethyl Penicillin

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana.

Lilly

500990

EDITORIALS

Those Little Red Seals

Traditionally, red and green seals have been the symbols of excellence. This month our state's Tuberculosis and Health Association opens its 59th annual campaign against respiratory disease. As doctors, we have primary professional responsibility in this campaign. But the community at large is responsible for public education, fund raising, mobilizing professional knowledge for physicians and health personnel, and furnishing leadership in research. In implementing these heavy responsibilities, the Christmas Seal Campaign is a major weapon.

Last year, almost 3000 people in New Jersey were listed as new cases of tuberculosis. This is a significant increase over the 1963 total of 2,867 new cases reported. There are now more than 15,000 known cases of tuberculosis in the state. These are people who require varying degrees of care, from months of hospitalization to periodic medical check-ups. Christmas Seal donations help provide services to seek out unsuspecting victims of tuberculosis. They help assure prompt diagnosis and treatment and protection against recurrence.

Respiratory illnesses are the leading cause of time lost from school and work and the tenth leading cause of death. Christmas Seal funds are providing scientists with research money for lung function studies.

New Jersey Tuberculosis Associations also support medical research projects in respiratory diseases and provide fellowships to physicians for advanced study and teaching in chest diseases.

A year-around professional education program enables New Jersey doctors and nurses to attend major medical conferences which bring them the latest information on treatment and care of patients.

Some of the "lay health organizations" have occasionally irritated physicians by amateurish educational efforts, by interposing themselves between doctors and patients, by diverting excessive budgets to administration, or by downgrading the doctor's role. But the New Jersey Tuberculosis and Health Association has always been our partner in the twin-pronged campaign against respiratory illness. George N. J. Sommer, Jr., M.D. of Trenton is the President of the Association.

The program merits our support.

Virtuosity, Craftsmanship, And The Medical Generalist

Virtuosity is, perhaps, an old-fashioned word for technical skill displayed with a high order of craftsmanship. It is traditionally contrasted with a kind of depth or wisdom, a broad-gauged sagacity now called "excellence." Or, to put it another way: excellence in a narrow field becomes virtuosity.

To develop virtuosity, one must specialize. You cannot become a piano virtuoso if you also divert time to football, writing novels, play-acting, and solving quadratic equations. There seems to be no substitute for incessant practice and concentrated experience.

The physician may have to choose. A skilled surgeon may elicit applause because of his manual deftness. However, if he cannot also make discriminating surgical diagnoses; if he does not see his patients as human beings rather than as pieces of tissue; if he cannot, through the laying on of his hands, transmit compassion as well as craftsmanship, then he is not a great doctor. Of course, he has to have the technical skill, too. But since virtuosity requires so much energy and time, the

skilled practitioner hesitates to become broader, lest he also become shallower. Furthermore, the virtuoso may be afraid of innovation. Having established a masterful habit pattern in his skilled area, he is unwilling to change it. Thus, virtuosity without breadth, without general "excellence," leads to pedantry and doctrinairism.

He who is not specialized, but equally intelligent, just as well motivated, and possessed of character, will have a profounder knowledge and a more rounded excellence. The public admires the specialist. It is easier to applaud virtuosity than to accolade profundity of thinking. We shout "bravo" at hearing (and seeing) a tricky piano sequence, a complex dance, or an extraordinarily skillful bit of operative surgery. It is not so easy to see, react, and applaud sensitivity to human thinking and feeling. The truly great medical or surgical specialist has to be a great and good physician: and, beyond that, a curious, sensitive, and broadly knowledgeable man.

Also related to this is the question of responsibility. The general practitioner takes responsibility for the health care of the individual. The engineer or builder takes responsibility for putting up the entire structure and all of its equipment. The athletic coach in the small college takes responsibility of *all* sports.

In medicine today a number of factors encroach on individual responsibility. One is group practice; another is specialization; a third is teamwork; and a fourth is hospital practice. As these components operate, a situation develops where no one doctor has general responsibility for a human being. In our present state of medical development it is hard to see what doctor can be given total responsibility. The only physician likely to understand the overall personality of the patient is the psychiatrist; and none of the other specialists is going to subordinate himself to the leadership of the psychiatrist.

An analogy might be made to an orchestra where each individual player displays virtuosity by contributing to the harmony of the entire orchestra. The only creative person there is the conductor; and it may well be that the conductor cannot play any of the instruments. In this case, the conductor lacks virtuosity or craftsmanship, but has an overall and profound understanding of the art; whereas the individual players will contribute only their technical skill. Translate this into the field of medical teamwork and you can see how specialization tends to destroy responsibility without reducing the skillfulness of the individual specialist.

Progress in medical science is achieved by specialists. Yet, by the narrowness of their outlook, specialists are unlikely to be creative except in their own field. And failure to see the total picture and see it in the round is an impoverishing experience. Up to the turn of the twentieth century, most creative progress in medicine was made by non-specialists. Today the basic discoveries are achieved by specialists, but their application waits the creative imaginations of the better rounded practitioner.

One would hope that medical schools would look with more favor on the applicant with a rich background in the humanities. He will get little of that in medical school—whereas he will get a lot of physiology, biochemistry and medical physics there. Many high places in the medical school faculties are today held by specialized scientists. And since they see future doctors in their own image, their screening of applicants will be influenced by their concept of what the M.D. should be. Let it be hoped that the cause of breadth, depth, and scholarly excellence will not be lost by blindly following the model of the specialized scientist.

BICENTENNIAL CELEBRATION
Annual Meeting
Friday-Wednesday
May 14-18, 1966
Haddon Hall, Atlantic City

ORIGINAL ARTICLES

Cardiac arrest is a dramatic medical emergency requiring instant and effective treatment. Here is one mechanical device that has saved some lives and can save more.

Mechanical External Cardio-Pulmonary Resuscitation

John J. Tambascia, M.D./Kendall Park

In 1878, Boehm[1] showed the efficacy of external cardiac massage in animals with cardiac arrest. But it was not until 1960 (when it was popularized by Kouwenhaven, Jude and Knickerbocher[2]) that external cardiac massage became widely accepted in human resuscitation. Combined with mouth-to-mouth resuscitation, an increasing number of successful resuscitations following cardiac arrest have been reported.

Most people who experience cardiac arrest cannot be saved. However, prompt use of cardiopulmonary resuscitation has enabled some lives to be saved that otherwise might have been lost. The uniqueness of these two procedures lies in the fact that they may be administered by anyone, anywhere, trained in the technic. If cardiac massage is to save lives, first aid workers and many para-medical personnel must be trained in it. But since many untrained personnel have come to try external cardiac massage, the problems and dangers in these procedures now become important. External cardiac massage is exhausting and often needs a change of operators. In most adults, a force of 90 pounds and as high as 130 is required to compress the sternum. Injuries to patients—including damage to the heart, liver, multiple rib fractures, puncture of the lungs, and bone marrow emboli—have been reported. Usually, these injuries result from unequal, improperly directed forces to the sternum. The patient must first be moved to a hard surface, which is time consuming. Two persons are required: one to perform artificial respiration, the other to massage the heart.

The Machine

To overcome these problems, a machine (The Tamband Heart-Lung Resuscitator) has been developed to do cardiac massage and mouth-to-mouth resuscitation simultaneously and synchronously. (See Figure). The machine has a base [which can easily slide beneath the patient] upon which the thorax rests. A posterior fixation block is located on the base. This fixes the vertebral column and maintains the proper position of the patient so that the force applied to the sternum is correctly applied to the heart. An upright support encloses two gas cylinders for use when the machine is operated away from a piped-in supply or a ready supply of compressed gas. The functioning components of the machine are encased in the horizontal portion, the height of which is adjustable on a vertical support. A plunger extends from the horizontal support, at the end of which is a compressor pad, so contoured as to engage the lower one-third of the sternum. The power source is an air motor. Compressed gas (oxygen, nitrogen, et-



FIGURE I. Tamband Heart-Lung Resuscitator.
(Courtesy Medi-Tech Laboratories, Madison, New Jersey.)

cetera) provides the energy. The machine weighs 32 pounds.

The stroke of the plunger can be regulated from one-half inch to two inches. Its rate can be regulated from zero to one hundred and twenty strokes per minute. A force of approximately one hundred pounds is applied to the sternum by the compressor pad. One unique feature of the machine—and an important functioning component—is an air bellows which dispells up to a thousand cubic centimeters of air or oxygen on every fourth upstroke of the plunger. As the length of the stroke is decreased to perform cardiac massage on an infant, the amount of air ejected is automatically and synchronously reduced so that the proper volume of air or oxygen is released for the individual depending upon size. At a stroke of one-half inch, 150 cubic centimeters of air or oxygen are delivered. At a two inch stroke, some 850 cubic centimeters of air or oxygen are delivered. One adjustment determines the stroke of the plunger, its rate, and the amount of air or oxygen dispelled.

Mechanical Vs. Manual Closed Chest Resuscitation

In comparison to manual external cardiac massage and mouth-to-mouth resuscitation, the machine never tires. It delivers the proper force to the sternum. The machine will direct the force in the appropriate direction. The sternal displacement, according to the size of the patient, is performed. There is uniformity of impulse. Cardiac massage is maintained at a constant rate. A base is provided to place under the patient to give counter-pressure. It eliminates the need to move a patient to a hard surface. A fixation block is available to engage the vertebral canal preventing undue movement of the patient. It also acts as a counter-pressure mechanism. The machine coordinates external cardiac massage and pulmonary ventilation preventing sudden increases in intra-pulmonary pressure with rupture of the bullae and alveoli.

Clinical Experience

This device has been used in over two hun-

dred cases of cardiac arrest without one single case of laceration of the liver, bone marrow embolism, tear of the pericardium, or fracture of the sternum. Here I present 92 cases of cardiac arrest chosen at random in which this machine was used.

Eighty-five per cent of the patients were on the medical service and fifteen per cent were surgical. Those treated for cardiac arrest in the emergency room or intensive care unit are included in the medical service. Sixty per cent of the patients previously had heart disease, half of whom carried the diagnosis of acute myocardial infarction. Four per cent of the arrests occurred in the operating room. We divide the cases into four groups:

Group I —Successful patients: those who survived with little or no effect (9.8 per cent).

Group II —Temporary successful cases: those who resumed spontaneous cardiac and respiratory activity for more than one hour but did not survive (50 per cent).

Group III—Technically satisfactory cases: patients who never resumed spontaneous cardiac and respiratory activity but in whom satisfactory peripheral pulses and femoral arterial pressure were noted and in whom pupils remained constricted for at least fifteen minutes (30.4 per cent).

Group IV—Unsuccessful cases: patients who did not fall into any of these categories (9.8 per cent).

Fewer than 10 per cent were successfully resuscitated. But note that resuscitation was tried in some cases in which there was little hope. This does demonstrate the value of external cardiac massage in cardiac arrest. It shows that patients could be returned to a useful life without sequellae. The most important aspect of this study is that *not one single complication was noted.* Those who did not survive were examined at autopsy for evidence of fracture of the ribs, fracture of the sternum, hemopericardium, rupture of the diaphragm, bone marrow emboli or pulmonary fat emboli. In comparison with studies in which external cardiac massage was done manually, a marked difference was noted in the incidence of these complications. Hummelhoch[3] and his associates reported the following incidence of complications following manual external cardiac massage: fractures of the rib—47 per cent; pulmonary bone marrow emboli—27 per cent; hemopericardium—2 per cent; and pulmonary fat emboli—42 per cent.

Baringer and his co-workers[4] reported an incidence of 33 per cent rib fractures; liver injury, 11 per cent; and marrow emboli, 73 per cent following manual external cardiac massage.

These data point up the value of mechanical external cardiac massage and mouth-to-mouth resuscitation. The absence of serious complications is attributed to the fact that the machine delivers the proper force in the right direction; it eliminates forces directed toward the adjacent structures which are responsible for injuries to these organs. Because of the structure of the machine, motion on the part of the patient is eliminated and the heart is massaged or compressed more efficiently. This leads to more effective systemic circulation. It provides a means by which external cardiac massage and mouth-to-mouth resuscitation can be done by one person.

Summary

1. A comparison of mechanical external cardiac massage and pulmonary aeration to manual external cardiac massage and mouth-to-mouth resuscitation is made.

2. The Tamband Heart-Lung Resuscitator is described and illustrated.

3. Over two hundred cases of cardiac arrest have been treated without one serious complication.

4. A study of 92 cases of cardiac arrest treated by mechanical external heart lung resuscitation is presented.

5. The value of the use of mechanical heart lung resuscitation in the treatment of cardiac arrest is emphasized.

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Prognosis in prostatic cancer depends on the histologic type and its natural history as well as on the treatment technics used.

Anatomic and Biologic Factors in Prostatic Cancer*

Anthony R. Fernicola, M.D./Newark

The biologic potential and behavior of prostatic carcinoma are assessed by conventional tumor grading and staging. These values are substantiated by enzymatic and roentgenographic findings and constitute the criteria by which prognosis and application of therapeutic modalities are determined. Classification is essential to a proper perspective by which prognosis and management can be appraised. Unfortunately, in practical terms, the uncertainty of the extent and of dissemination of prostatic carcinoma precludes a definite baseline from which the natural history of the neoplasm or the efficacy of therapy can be measured. An analysis of *clinical* data (which reflect the characteristics and sequences of treatment of prostatic cancer) gives insight into the clinical and pathologic variables and comparative efficacy of treatment.

Incidence

Prostatic cancer may be regarded as the ultimate manifestation of male senility. One hundred percent of men over 90 years of age and 90 percent of men over 80 years of age have histologic carcinoma of the prostate. In men over 65, cancer of the prostate is the most common malignant neoplasm exceeding that of the stomach, lung, and skin.[1] Prostatic carcinoma has been estimated as being present in from 14 percent to 50 percent of men over 50 years of age in the United States. It accounts for 12 percent of male deaths from cancer throughout the United States.[2] It is rare in Orientals, Filipinos, and Mexicans.[3]

In 1961 in the United States, the male population numbered 90,000,000. By then 20,000,000 men had reached the age of 50. This population (20,000,000 men beyond the age of 50) yields 4,000,000 men with latent carcinoma. Fifteen thousand deaths each year develop from a persisting pool of more than 4,000,000 men with cancer.[4] However, more individuals die *with* prostatic cancer than die *of* it.

Etiology

In 1941 Huggins' "biologic syllogism" was regarded as the breakthrough toward an understanding of the behavior of neoplastic prostatic tissue.[5] It stated that malignant prostatic tumor is an overgrowth of adult epithelial cells. Adult prostatic epithelium undergoes atrophy when androgenic hormones are reduced or inactivated. Therefore, significant improvement should occur in the clinical condition of the patient with far advanced prostatic carcinoma if he is subjected to castration or estrogen. This premise is based on the histochemical localization of acid phosphatase in adult prostatic epithelium. The impact of this theory may be dampened by the recent demonstration of acid phosphatase in embryonal prostatic epithelial cells.[6] Heretofore acid phosphatase was not known to be present in embryonal or pre-puberal prostatic epithelium. Acid phosphatase is present in normal adult epithelium, the epithelium of nodular hyperplasia, and in local and distant prostatic carcinoma.

Theories ascribing the cause of prostatic can-

* Read May 17, 1965 at the Annual Meeting of the Medical Society of New Jersey.

cer to androgens have failed. Androgen has *not* been known to produce prostatic carcinoma in man or animal. It is also difficult to reconcile that, at an age when prostatic cancer develops, urinary androgen titres are low. The extent to which carcinoma of the prostate gland is a hormonal-dependent disease is unknown. An acceptable working hypothesis is that prostatic cancer results from a disturbance of the ratio in quantity of both circulating estrogens and androgens in the older man.[3]

Pathology

A distinction is required between the *disease of prostatic cancer* which behaves in same way as cancer does in other sites, and an area with histologic structure of prostatic carcinoma. "Latent" (occult) carcinoma consists of isolated areas with the histologic structures of prostatic carcinoma in contrast to "manifest" (clinical) carcinoma of the prostate. Both types exist and are histologically identical; but their biologic behavior and clinical course differ. *Active* carcinoma eventually kills. But the "incidental" lesion is found at autopsy or at surgery. It is reasonable to assume that the hormonal environment in the host may influence "latency" or accelerated growth potential of prostatic cancer. The only reliable method for differentiating latent and active prostatic cancer is the behavior of the patient. Many cancers of the prostate are so slow in development that they never become clinically apparent.[7]

The embryologic significance of prostatic tumor growth is of interest. The prostatic urethra is of dual origin. The *proximal* portion ("true urethra") lies above the openings of the Wolffian (ejaculatory) ducts and is of mesodermic origin. The *distal* portion of the prostatic urethra extends from the openings of the Wolffian ducts to the membranous urethra and arises from endoderm. Pathologists attribute the development of benign hyperplasia from the proximal portion and carcinoma from the distal portion. These areas are also referred to as the "anterior lobe" or "inner" zone and the "posterior lobe" or "outer" zone. Few data are available regarding distinct functional and biochemical differences in each zone of the prostate. It is generally agreed that the behavior of carcinoma in the central portion of the prostate differs from that in the capsular portion where 95 percent of carcinoma originates.

Controversy exists regarding the widespread notion that most prostatic tumors originate in the posterior lobe. The posterior lobe constitutes an independent structure by virtue of its embryologic derivation and anatomic delineation. There is no unusual increase in incidence of malignancy in the posterior lobe delineated by the urethra and ejaculatory ducts. Tumors originate either posterior or anterior to this line of demarcation established by the ejaculatory ducts. Rectal palpation cannot distinguish lateral and posterior lobes, and thus one considers the posterior lobe to occupy approximately 50 percent of the bulk of the gland. If one restricted the posterior lobe to a wedge-shaped area (posterior to the urethra and ejaculatory ducts), fewer tumors would be said to arise in this region. The peripheral or subcapsular region is the common site of origin. Most significant is the observation of multiple tumor foci. We now know that the incidence of multiple-originating prostatic tumors is greater than we once believed.

All prostatic carcinomas are histologically identical, but their biologic behavior differs, probably according to their hormonal environment. No uniform patterns are seen. Areas of different grades lie side by side. The tumor is classified according to the highest grade found on histologic examination.

Poorly differentiated tumors have considerably poorer prognosis than well differentiated tumors. Metastases are more frequent in the former than in the latter. Almost three times as many patients with poorly differentiated as with well-differentiated lesions display evidence of metastases. Poorly differentiated tumors have strong inherent tendency to metastasize irrespective of local extension, and poorer response to endocrine and surgical treatment. One clinicopathologic survey[8] dis-

closed five year survival rates for well and poorly differentiated cases to be 79 percent and 49 percent respectively, and the 10 year rates to be 49 and 14 percent respectively. This would indicate that the histologic grade of tumor differentiation was the most valuable guide to survival.

Classification

Staging of prostatic cancer designates a clinical appraisal of the extent of tumor growth. It characterizes the lesion by connoting a phase in the dynamic course of its invasive potential. Staging is, in large measure, an arbitrary assessment. It is not an unequivocal criterion for prognostic and therapeutic deductions. Local spread, lymph node, and bone marrow involvement are often elusive developments. About half of the cancers judged clinically to be confined to the prostate may be proved[9] (by histologic examination of the operative specimen) to have extended locally beyond the prostate. Also, a palpable solitary nodule may be only one of multi-focal lesions within the prostate. Perineural lymphatic invasion is virtually a constant feature except in latent carcinoma. The occurrence of regional lymph node metastases within the confines of the pelvis does not preclude the simultaneous metastases to para-aortic and paracaval lymph nodes from which hematogenous spread probably arises.

Whitmore[4] has tried to correlate clinical staging with the natural history of prostatic cancer. Here is his schema:

Stage A is *latent* carcinoma, found only on histologic examination of prostatic tissue found at autopsy or at surgery. The lesion is not clinically suspected nor recognizable. It is common in older men and sometimes it takes 20 years before the carcinoma becomes clinically manifest.

Stage B is clinically early cancer. It is demonstrated by a palpable nodule apparently confined within the prostatic capsule. The patient is asymptomatic: and there is no enzymatic, clinical, or roentgenographic evidence of local extension or metastasis. No statistics are available to indicate the average life expectancy of untreated patients with clinically early prostatic cancer. Evidence suggests, however, that an extremely long natural history for some Stage B prostatic cancers occurs.

Stage C cancer is that which is locally extensive without evidence of distant metastases. An area of abnormal induration extends locally beyond the capsule to adjacent structures. There is no clinical, laboratory, or roentgenographic evidence of metastases. The five year survival rate for untreated Stage C disease is about 10 per cent.

Stage D cancer is clinically metastatic and characterized by definite evidence of distant metastases in bone, lymph nodes, or other sites. Five year survival in the untreated Stage D lesions is about 6 per cent.

A classification is offered by Flocks,[10] which relates the occurrence of lymph node and bone metastases to the extent of the prostatic lesion, as follows:

Stage A. Lesion completely limited to prostate.

Stage B. Lesion completely limited to prostate, except that some pelvic lymph nodes involved.

Stage C. Lesion locally extended beyond prostate to capsule, base of bladder, area about seminal vesicles.

Stage D. Lesion locally extended beyond prostate, plus involvement of pelvic lymph nodes.

Stage E. Lesion locally extended beyond prostate, plus dissemination to bones.

In cancer limited to the prostate, 8 percent show positive pelvic lymph nodes. In locally extensive disease, 40 percent show positive pelvic lymph nodes with normal acid phosphatase and with no demonstrable bone metastases. A 10 percent incidence of positive cells by bone marrow aspiration was found by Flocks[10] with lesions limited to the prostate, negative x-ray findings, and with normal serum acid and alkaline phosphatases. Bone marrow involvement may be regarded as virtually universally present late in the disease.

The classification of Hudson and Stout[11] provides criteria for more aggressive surgical management. It differs from Whitmore's classification with respect to Stage C, in which two groups are recognized. In one subgroup, the tumor extends into the fascial covering of the seminal vesicles. In the other subgroup, local invasion penetrates into surrounding structures with no enzymatic or roentgenographic evidence of metastases. They regard the former group curable by surgery.

Discussion

The natural history of prostatic cancer provides the control source from which therapeutic modalities are evaluated. Many aspects

of the natural history of this cancer, however, are unknown; and thus, a critical evaluation of the attributes of various curative or palliative methods is not indisputable. A long natural history of a particular prostatic cancer may be responsible for survival, although the clinician would credit this to therapy, particularly in respect to low stage, low grade tumors. It is further reasonable to assume that with early lesions, the survival would vary inversely with the grade of the neoplasm. Certainly, there is a marked propensity for prostatic cancer to metastasize to lymph nodes. The presence or absence of lymph node and bone marrow involvement is difficult to correlate with survival following therapy for early cancer. Surgical or autopsy findings with clinically defined stages will often reveal the neoplasm to be far more extensive both locally and metastatically than was clinically appreciated. Local recurrence with death of the patient in whom radical prostatectomy had been done raises the question as to whether local recurrence was the precipitating cause of death or whether it was a concomitant manifestation of an already existing adverse situation.

The formidable approach to prostatic cancer engages deterrent factors related to one's ignorance of the natural history of the neoplasm, the presence of perineural lymphatic invasion, the inaccuracy of clinical estimation of the pathologic extent of the tumor, the uncertainty of lymph node and bone involvement, degree of anaplasia of the tumor, hormonal influences on tumor growth, and life expectancy of the individual. Certainly conclusions regarding the most efficacious methods of treating prostatic cancer cannot be drawn. A reflection on these facts commits one's judgement not to a decision of what *can* be done but of what *should* be done.

Prostatic cancer is a common and lethal disease and will persist unless subjected to ablative surgery which at the present time would afford the only available cure of early carcinoma of the prostate. There can be no quarrel with this principle, provided the premise for this conclusion could be established as true and unequivocal in respect to the existence of *early* prostatic cancer. However, the deceptive and unpredictable behavior characteristic of prostatic cancer precludes the unequivocal designation of *early* cancer, so that in a strict sense the indication for ablative prostatic surgery is not absolute.

Conclusions

1. Each prostatic cancer and each host is a complex variable.

2. It is virtually impossible to determine with accuracy how important a specific therapeutic modality may be in overcoming the lethal effects of prostatic cancer.

3. In the light of the characteristics of the biologic behavior of prostatic cancer, definitive therapeutic measures cannot be specified and the adequacy of treatment appears difficult to establish.

4. Since no presently known therapeutic modality can be guaranteed to cure, the objective is to seek the best method or combination of methods of treatment.

5. The selection rests upon the sound judgement of the urologist in his balanced consideration of the life history of the host, as well as the life history of the tumor.

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402 Mt. Prospect Avenue

Congenital absence of the gall-bladder is not only rare; to the diagnostician, it is downright confusing.

Congenital Absence of Gallbladder

John Hammond, M.D.
John Wise, M.D.
Thomas K. Rathmell, M.D. / **Trenton**

A 61-year-old woman was admitted to The Mercer Hospital with upper abdominal distress which had been present intermittently over the past eight years. Her current symptoms consisted of pain, occasional nausea, and vomiting. During the past three months, these complaints had become more pronounced. She was a well-developed and well-nourished female without specific complaints referable to any particular area. Chest x-ray was negative. A gastro-intestinal series and electrocardiogram were within normal limits. There was, however, some evidence of left ventricular hypertrophy, and the aorta was considered to be elongated. Oral cholecystogram failed to demonstrate the gallbladder shadow on double intensification, and a diagnosis of chronic cholecystitis was made.

Laboratory studies (urinalysis, hemoglobin, red, white and differential cell counts) were normal. Blood urea nitrogen was not elevated. Four days after admission, at exploratory laparotomy, the surgeon reported that he could not find the gallbladder. A cholangiogram, done in the operating room, showed the hepatic ducts and their radicles to be normally outlined. The distal portion of the common duct was visualized as normal. There was no visualization of a gallbladder section and no dilatation of the common duct. It was first thought that this finding was accounted for by previous cholecystectomy. But, there was no evidence of this (either historically or by the presence of abdominal scars indicative of previous surgery in this area). The operation was terminated with a diagnosis of congenital absence of the gallbladder.

Congenital absence of the gallbladder is compatible with a long life, although other abnormalities incompatible with life may be present coincidently. The possibility of deep-seated gallbladder was considered, as well as the possibility of calculus formation at the origin of the cystic duct, but this was not proved by cholangiogram.

It is usual to do a cholangiogram by catheterizing the cystic duct. In this instance, however, a small puncture was made with an eighteen-gauge needle in the common duct, and a catheter inserted through which the dye was injected.

On routine necropsy, congenital absence of the gallbladder is noted in 0.03 to 0.09 per cent of cases. The finding is thus somewhat unusual.

Embryologically, immediately distal to that portion of the entodermal tube which becomes the stomach, there arises an outgrowth which is destined to become liver. This outpouching divides early in embryologic life into a small caudal branch which differentiates into the gallbladder, while the cephalic portion of this structure develops into the right and left hepatic ducts and bile capillaries with surrounding entodermal cells which constitute the parenchyma of the liver. The vessels of the liver take origin from the meshwork of vitelline veins.

Complete absence of the gallbladder has been reported in association with absence of the bile ducts and also in some instances in which the remainder of the biliary system was normal.

The Mercer Hospital (Dr. Rathmell)

Subclinical hypopotassemia in cardiacs may go unnoticed and may interfere with the patient's recovery.

Hypopotassemia: Roadblock To Cardiac Rehabilitation**

Roger W. Cooper, M.D./Newark

The effects of potassium on transmembrane action potentials, conduction fibers, and the electrocardiogram are well known.[1] The electrocardiographic abnormalities of hypopotassemia commonly involve the S-T segment, T-wave, and the U-wave. However, the electrocardiogram may not be specific until plasma potassium concentrations are at or below 2.3 milliequivalents per liter. This is diagnostic in advanced (but not in moderate) hypopotassemia. Digitalis frequently causes patterns similar to hypopotassemia even when plasma potassium concentration is normal.

The following case illustrates a situation frequently seen in our laboratories where "subclinical" hypopotassemia thwarts all attempts to build up work tolerance in persons with ischemic heart disease, until the condition is identified and corrected.

A 50 year old man had been hospitalized for chest pain, shortness of breath, and tachycardia six months previous to his referral to our cardiac rehabilitation clinic. A diagnosis of acute coronary insufficiency was made while in the hospital. After discharge, he was bothered by mild attacks of angina pectoris and symptoms of congestive failure. He was on digitalis and thiazide diuretics with no signs of failure when rehabilitation was started. He had a repeatedly low coronary flow index and a strongly positive Double Master's Test for ischemia. He complained of easy fatigability and was unable to do his work as a plumber. Several weeks of maximally tolerated work loads produced no progress in function. A test load of 5 grams of potassium choloride orally was seen to improve his exercise electrocardiogram. Some days later we repeated this test, monitoring the potassium concentration, electrocardiograms, and post-exercise pulse recovery rates.

Methods

The exercise electrocardiograms were performed by Telemetry† using the standard Master's steps. Thirty-eight steps were done in exactly three minutes in each test. Serum potassium levels were determined with the Perkin-Elmer flame photometer using the lithium internal standard. All blood samples were split and each fraction analyzed twice for potassium.

Three control serum samples were drawn for potassium determinations, one hour, thirty minutes, and immediately before 5 grams of potassium chloride given orally in vegetable juice. Control (before potassium chloride) Master's Test was done immediately after the second control serum potassium determination. After the ingestion of the potassium, serum potassium determinations were then done 30, 60, and 90 minutes thereafter. The Master's Test (after potassium chloride), performed exactly as before treatment, was done one hour after the test potassium dose.

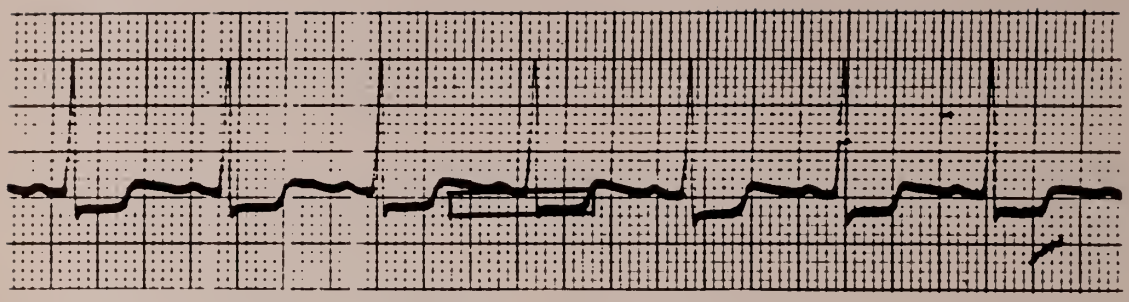
Serum potassium concentration, pulse rates, and a sample electrocardiogram taken four minutes after each Master's Test are shown.

Time	*Serum Potassium Concentration*
1 hour before potassium chloride	3.27*
30 minutes before potassium chloride	3.07*
0 minutes before potassium chloride	3.36*
5 gm. potassium orally in vegetable juice	
30 minutes after potassium chloride	4.54*
60 minutes after potassium chloride	4.66*
90 minutes after potassium chloride	4.59*

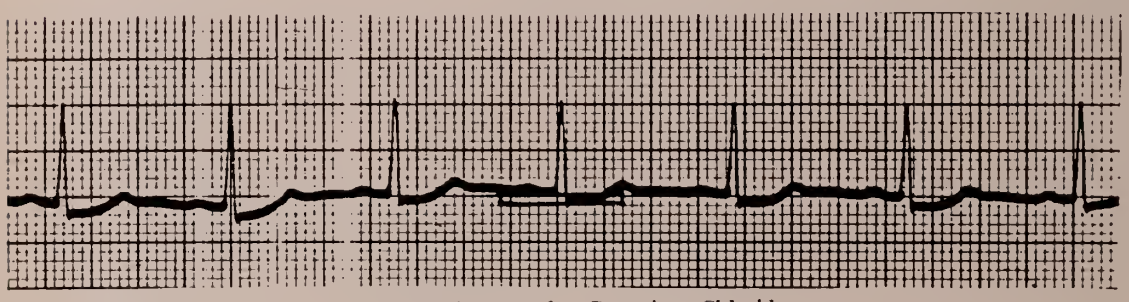
** From the Research Department of Columbus Hospital, Newark, Michael C. Ritota, M.D., Director. Flame Photometry kindly performed by Schering Corporation, Bloomfield, New Jersey.

† R.K.G. 100 Radioelectrocardiograph, Manufactured by Telemedics, Southampton, Pennsylvania.

* Expressed in milliequivalents of potassium per liter



Electrocardiogram before Potassium Chloride



Electrocardiogram after Potassium Chloride

Post-Exercise Pulse Rates

Time	Immediately After 38 Steps	1 min.	2 min.	4 min.	6 min.
Before Potassium Chloride	124	95	86	93	84
After Potassium Chloride	118	90	75	84	79

Average Mean Post-Exercise Rate is 96/m. before potassium chloride

Average Mean Post-Exercise Rate is 89/m. after potassium chloride

Patient experienced less fatigue at completion of the Master's Test, after the potassium chloride loading dose.

After this test the patient was put on a high potassium diet and supplemental potassium. His work capacity soon rose to over twice its previous level (600 K.P.M. ergometric), and he was able to return to his previous job as a plumber.

Discussion

Subclinical hypopotassemia in cardiac patients, especially those on thiazide diuretics, is undoubtedly common, and often so insidious as to go unnoticed for long periods of time. When one is attempting to regain lost function in patients with ischemic heart disease, all biochemical systems involved must be brought to optimal conditions; the patient must be fully compensated and in perfect electrolyte balance. Our approach to rehabilitation by "chronic progressive overload" exercises demands optimal metabolic support.

A word of caution: patients with heart disease frequently do not handle potassium in the same manner as normal subjects.[2] Normal kidney function is mandatory before attempting potassium therapy. Recently, small bowel ulceration has been associated with enteric-coated potassium medications.[3]

Summary

Hypopotassemia is often an important factor preventing rehabilitation of patients with ischemic heart disease. A case history illustrative of this problem is presented.

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495 North 13th Street

Because the findings so often don't seem objective, it may be hard to write a vivid psychiatric report. Here is a simple example.

How To Write A Psychiatric Disability Report

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/ **Newark**

To a large extent, it rests with the attending psychiatrist whether his patient will get a prompt decision on his social security disability claim. Each year, New Jersey practitioners in all specialties prepare 25,000 reports, about half of which do not initially give enough detailed findings to permit a determination as to whether the patient is "disabled" within the meaning of the law. Experience has shown that many physicians have this information in their files and are readily willing to provide it when contacted a second time.

Disability determinations on residents of New Jersey are made by an evaluation team in a local agency. The team in New Jersey includes a practicing physician (working part-time in the Disability Determination Service of the New Jersey Rehabilitation Commission) and a trained counsellor. The services of a psychiatrist are available to the agency to assist in the evaluation of cases involving psychiatric impairments.

To help in visualizing the evidence that the Disability Determination Service needs, we have presented in previous issues of this JOURNAL some typical case examples and ways of reporting them. Here we consider an applicant with a psychiatric impairment, as an example.

When a psychiatric case is received in the State agency, it is reviewed to see if the file contains enough information to permit a decision. The reviewing physician never sees the patient. He works entirely from the reports that are submitted, plus other written evidence, to decide whether the patient has an impairment that qualifies him for disability benefits. The feasibility of offering the patient rehabilitation services is also considered in all cases, even if the patient does not qualify for disability payments.

The social security law defines disability as inability to do any type of substantial gainful work because of a medically determinable impairment. The condition must be expected to be of long-continued and indefinite duration despite adequate therapy, or else to end in death.

To reach a conclusion as to the severity, duration, and remediability of the patient's impairment, the reviewing physician needs detailed information, such as the results of mental status examinations and the results of electro-encephalograms, as well as functional capacity observations. Frequently this evidence is available in the treating psychiatrist's records. However, if he does not put this in his initial report, a "follow-up" is necessary. This takes up his time and, of course, delays the decision on his patient's case.

Psychiatric Impairment

John Smith, a 33 year old salesman, applied for social security disability benefits in August

of 1964. He told the social security district office representative that he had quit work in February 1964 because he had a "nervous crackup." He said he was depressed, nervous, and couldn't stand to be around people. He had been employed in a number of different jobs for brief periods each, but that most of his experience was in door-to-door selling. He said that he had been working his way through college when he had the "breakdown," which he ascribed to economic pressures that broke up his home. He had married in college and had two children. The marriage ended in divorce in October 1963 (principally due to arguing over finances, he said). Mrs. Smith has both children.

Mr. Smith has been seeing Dr. Adams, a psychiatrist, since February 1964. He lives by himself in a furnished room, and informed the district office representative that he is supporting himself on savings. Mr. Smith takes care of his daily needs and drives his car wherever he wants to go. He spends most of his time walking around the town and drinking coffee in the haunts of his former college crowd. He likes to talk to his former college associates.

Dr. Adams sent in a medical report form which was studied by the physicians in the Disability Determination Service. Here is the report.

The patient is 33 years old, 67 inches tall, and weighs 166 pounds. He complains of "nervousness" and depression. A meticulous physical work-up did not establish any organic disease. The patient is ambulatory. I advised him to avoid crowds, noise, and tension. I am giving psychotherapy, but there has not been much improvement. My diagnosis is "paranoid personality." The degree of impairment is moderate. Mr. Smith has not worked since February 1964.

Dr. Adams' report helped the evaluation team. It sufficed for a casual case summary. But it did not give enough information to permit a fair evaluation of the case. It did indicate that Mr. Smith had an impairment which was causing him some distress. However, the report did not permit a reviewing physician to determine precisely (for disability evaluation purposes) the severity of the condition and the patient's ability to perform work-related functions. Without such information, the evaluation team cannot conscientiously determine whether to allow or to deny the patient's claim. The treating physician was requested to provide additional information, which he did in the following letter:

In reply to your inquiry, I can provide you with the following information about my patient, Mr. John Smith. He first came to me about a year ago, complaining of depression and general "nervousness." The patient describes his youth as unhappy. He left home upon graduation from high school. He worked at a variety of jobs thereafter, never staying in one for a long period. However, feeling the need for more education he entered college, intending to support himself by door-to-door selling in his spare time. He enrolled in college in 1961 on a full-time basis. Poor grades and poor finances kept him out of school for a couple of semesters. In his sophomore year, he met a local girl whom he married in February 1962. In March 1963, she gave birth to twin girls, a circumstance which placed heavy strain on the family's financial resources.

Despite Mr. Smith's efforts at increasing the time he spent selling, he was not very successful financially. There were many arguments between Mr. Smith and his wife over finances, his poor prospects, and his inability to support his family in an affluent manner. The arguments grew progressively more bitter. On one occasion Mr. Smith struck his wife and threatened to kill her. She fled with her children, and has subsequently obtained a divorce, as she was unable to reconcile her difficulties with the patient. Mr. Smith was forced to quit school in January 1964 to get a full-time job to keep up with support payments. However, one month later he stopped work altogether due to a "nervous crackup." He has not been employed since.

In March 1964, Mr. Smith came to me for assistance, complaining of "nervousness" and depression. I have seen him about once every two weeks since then. Mr. Smith is alert and well oriented to time, place, and person. His intelligence and use of language are above normal, and are consistent with his educational level. He is neat and clean. His prevailing emotion is one of depression, and he often weeps when he recalls the events surrounding the final break with his wife. Mr. Smith is highly irritable and is quick to take offense. He is suspicious and mistrustful, and expresses a great deal of paranoid ideation. However, he shows no other impairment of intellectual function. Memory is intact for both recent and remote events. He does serial sevens without difficulty and shows no evidence of impaired ability to concentrate. No abnormalities of speech, affect, or behavior are noted. The patient is free of hallucinations and delusions. No psychomotor retardation is present. Mr. Smith's judgment is intact, but he shows little insight into the nature of his condition.

On the basis of my treatment, I have arrived at a diagnosis of paranoid personality, manifested by mistrustfulness and suspiciousness of others, with moderate depression. I consider the degree of incapacity to be mild to moderate, and the prognosis to be fair.

This very helpful letter provides the Disability Determination Service with enough information to show that Mr. Smith is not disabled within the meaning of the law. While he does have a degree of impairment, there has been no severe interference with his functioning which would prevent him from performing some type of substantial work. He is able to think, reason, and communicate without difficulty, and has no emotional or psychiatric aberrations which seriously handicap him for performing work-related tasks.

Conclusions

It is sometimes difficult to communicate in writing a clear description of how emotional illness restricts an applicant's ability to work. However, an attempt should be made to describe the applicant's history, complaints, appearance, and other first-hand observations in detail. Any signs of loss of interest in personal appearance, impaired capacity for concentration, abnormalities of appetite and sleep cycle, pre-occupation with suicidal ideas, and other manifestations of serious emotional illness should be documented by specific examples.

If you have any questions about this article, or about the social security disability program, please contact the Disability Determinations Service on the fifth floor at 309 Washington Street, Newark, New Jersey. We will be glad to give you any additional information. Upon request, we will also furnish you with copies of the leaflet *The Psychiatric Report* or with brochures dealing with different impairments.

309 Washington Street

November is Life Month

"Life Month" refers to the life insurance plan endorsed by The Medical Society of New Jersey. November is "Life Month". During this month, members under age 65 may apply (subject to company approval of the applications) for up to ten $10,000 units providing term insurance coverage of $100,000. Insured members may apply to increase their present coverage up to $100,000, subject to a physical examination. Members who have converted previously issued term policies may apply for as much as $100,000 new term insurance.

During the past year, the amount of insurance available under the program has been doubled — to $100,000! These policies *include* double indemnity for accidental death and a waiver of premium benefit. More than 1700 of your fellow-members participate in the program, and claim benefits to beneficiaries exceed $900,000 to date.

The valuable conversion privilege in the policy has been exercised by many policyholders during the past year, to obtain permanent life insurance on a guaranteed issue basis without physical examination or evidence of insurability.

Our Society's life insurance plan has lower premiums than comparable policies obtained individually, and may be retained even if you retire or move out of New Jersey.

The increased dividend scale is being continued and the dividends have been announced for all policies renewing prior to December 31, 1966. The dividend is $25 per $10,000 unit for those ages 35 and under; $16 for those 36 through 40; $10 for 41 through 50; $6 for 50 through 60. This dividend scale will also apply to policies issued this year at their first annual renewal.

Members will receive complete information from the plan's administrator, E. & W. Blanksteen Agency, during "Life Month." Their address is 75 Montgomery Street, Jersey City 07302. They welcome your calls for information at Delaware 3-4340 area code 201; call collect, if you wish.

With a frequency of one anencephalic monster in 2000 live births, this distressing anomaly would merit further study. Dr. Stroup believes that couples who have two anencephalic monsters should resort to adoption for the rest of their family.

Anencephaly

Paul E. Stroup, M.D./Camden

A request for advice from a young couple who already had two anencephalic monsters prompted a review of the literature and a search of the files at The Cooper Hospital.

Incidence

In the last 16 years, 26 women were delivered of 29 anencephalics at The Cooper Hospital. During the same interval there were 59,402 live births. This ratio is 0.049 per cent and is less than the average reported incidence of 0.19 per cent.[10] The preponderance of white female anencephalics noted in previous studies[8,10,14] was confirmed by our study (Table 1). The mother's age does not seem to influence the incidence of anencephaly. In The Cooper Hospital survey, maternal age at the initial anencephalic birth varied from 17 to 37. Eleven mothers were younger than age 25.

Parity does not seem to influence anencephaly. One study[14] suggested a greater risk at the first parity and above the sixth. In our review, however, the parity (Table 2) prior to the birth of the first anencephalic was what one would expect from the general population. In addition, the previous pregnancy experience was normal in all respects. One might have expected an increased incidence of abortion since this has been reported by Malpas[9] in mothers of anencephalics. He also stated that anencephaly is an etiologic factor in spontaneous abortion,[9] which seems to be consistent with Potter's estimate of fetal malformations in 90 per cent of spontaneous abortions.[12]

Other factors supposedly related to the incidence of anencephaly are geographic location, season, economic status, family background, maternal blood type, and infectious epidemics.[6] In our study, information concerning these factors was unavailable.

Recurrence

Recurrence must be viewed not only in reference to anencephaly but also spina bifida. The two probably have a common etiologic factor.[8,11] Evidence for this is suggested by the association of spina bifida† in 10 to 20 per cent of cases of anencephaly[1,14] and the elevated frequency of anencephaly or spina bifida in the siblings of children born with either of these anomalies. According to Fraser,[4,5] when the *propositus* has anencephaly, the frequency of anencephaly and/or spina bifida aperta in the siblings ranges from 2 to 7 per cent. When the *propositus* has spina bifida aperta, the frequency of anencephaly and/or spina bifida aperta in the siblings is about 3 per cent.

In The Cooper Hospital study, data concerning the pregnancy experience following the first anencephalic was available in only 14 patients (Table 3). A total of 27 births occurred. Two were in second marriages and were normal but are here eliminated from consideration. There were no abortions. Five of the remaining 25 were born with congenital abnormalities and resulted from the first and second pregnancies following the anencephalic birth (Table 4). Four of the anomalies involved the central nervous system. This supports the statement[14] that the risk of recurrence of the same malformation is greater than the risk of a different one.[8]

† Seven of 29 in Cooper Hospital Study.

The sex of the initial anencephalic did not seem to influence that of the second child with a central nervous system defect. In two it was the same, and in two the opposite.

It is difficult to predict the pregnancy in which a second child with a central nervous system defect may result. The Cooper Hospital study suggests that a normal pregnancy frequently intervenes (Table 5). Several cases, however, have been reported with central nervous system defects in consecutive births.[7,13,15]

Comments

Fraser[5] has suggested that: "Some malformations are determined by gene mutations or chromosomal anomalies; others mainly by environmental teratogens; and others by a complicated interaction between multiple genetic factors and a variety of ill-defined environmental factors. Any specific clinical category of malformations is likely to be etiologically heterogeneous, containing examples of all three." This would seem to describe the current state of knowledge concerning the anencephaly-spina bifida complex. No chromosomal abnormality[3] has been discovered in anencephaly, but numerous teratogenic agents[10] have been determined. Applying the latter to an individual case, however, is difficult if not impossible. In view of this, suggested prophylactic measures[2] also would seem to possess little if any merit.[7] For the patient with repeated anencephalic births, adoption would seem to be the least traumatic as well as the most fruitful course.

Summary

Anencephaly occurs about once in two thousand live births. The literature concerning this anomaly and the experience at The Cooper Hospital have been described with special reference to the problem of recurrence. Adoption is suggested as the only practical measure for the patient with recurrent anencephalic births.

TABLES

Table 1

29 Anencephalic Births

26 White parents
3 Nonwhite parents

29 Anencephalic Babies

18 Female
11 Male

Table 2

Pregnancies Prior to First Anencephalic

Parity	*Patients*
0	8
1	7
2	6
3	2
4	2
5	1

(The 0 parity group included 3 abortions)

Table 3

Pregnancies After the First Anencephalic

Pregnancies	*Patients*
4	1
3	1
2	7
1	5
0	12

(The 5 included a set of twins)

Table 4

Second Anomalous Infant After An Anencephaly. Pregnancy indicated

Club foot	first
Spina bifida	first†
Spina bifida	second†
Anencephaly	second
Anencephaly	second

†One mother had a club footed infant in the first, and an anencephalic in the second, pregnancy after the first anencephaly. One spina bifida infant was also anencephalic; the other had a meningocele.

Table 5

Pregnancies In Which Anomalies Appeared

(This table refers to central nervous system anomalies only)

First Abnormal Baby	Case Number	2d Abnormal Baby
2d	1	4th
2d	13	3d
1st	19	3d
1st	24	3d

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618 Benson Street

Art in Philadelphia Medicine

From now through December 7, 1965, you can see the unique exhibition on "Art Philadelphia Medicine," displayed at the Museum of Art, 26th Street at Parkway, Philadelphia. The exhibit is open daily from 9 a.m. to 5 p.m. It will be closed on Election Day and Thanksgiving Day. Admission is free on Mondays; 50¢ each on other days. The display is to honor the 200th anniversary of medical education in the United States, which began with the founding of the School of Medicine of the University of Pennsylvania in 1765.

The exhibition is drawn from the rich historical and cultural resources of Philadelphia institutions and private collections; paintings, sculpture, prints, drawings, and artifacts never before assembled at one time. The exhibition traces the history of Philadelphia medicine from its British origins to the present day. Included is a depiction of medical science and teaching in 18th century London and Edinburgh, followed by portraits of famous colonial Philadelphians who trained there. Objects of the highest aesthetic and cultural importance trace Philadelphia's contribution to the development of American medicine—from the first hospital in this country to the latest example of medical architecture, and from early anatomic drawings and sculpture used in teaching to great paintings of the drama and rituals of surgical clinics.

Among the paintings there are works by the most prominent American artists of their time, such as Gilbert Stuart, Charles Wilson Peale, and Thomas Eakins. There are several busts by William Rush, the first important sculptor in America, as well as a collection of his famous anatomical models. Several prized collections of early medical instruments, early apothecary jars, and anatomic drawings are also on display.

A catalogue with reproductions of practically all of the 122 exhibited works has been prepared as a guide and reference to the exhibition.

For further details, write to "Medicine Exhibit," Museum of Art, 2600 Parkway, Philadelphia 1, Penna.

Anovulatory drugs may clear up acne in the female—but there are some prime emotional, pharmacologic, and psychologic factors to consider before embarking on such a regime.

Progestin-Estrogen Combinations in Management of Acne*

George H. Kostant, M.D./Irvington

That acne vulgaris is related to endocrinologic alterations is a well accepted concept. Sulzberger and Baer[8] considered acne a disease of hormonal imbalance with an alteration of the plasma androgen estrogen ratio. This hormonal abnormality in combination with a genetically predisposed pilosebaceous apparatus is the prerequisite for the disease.

Previous observations pointing to hormonal relationships in acne vulgaris may be summarized as follows:

1. It begins in puberty.
2. It occurs in ovarian and adrenal tumors.
3. It is absent in children.
4. It does not occur in male castrates. It may be produced by the administration of exogenous testosterone in these castrates.
5. It often improves with pregnancy.
6. It is often exacerbated premenstrually.

Acne vulgaris is essentially a disease of the sebaceous glands. These glands must be solely controlled by hormonal influences, since they have no motor innervation. Before puberty, they are small and inactive. At puberty, together with the development of the other secondary sex characteristics, the sebaceous glands increase to many times their former size and actively elaborate sebum. Acne occurs *only* in individuals with mature sebaceous glands. Acne is worsened when these glands are stimulated and is improved when these glands are inhibited. Sebaceous gland activity is completely under control of the androgenic hormone testosterone. Remove the source of androgen (as in castrates), and the sebaceous glands revert to their prepubertal size and activity. Add a small amount of androgen, and there is an immediate increase in size and activity of these glands. Androgens act *directly* on the glands. They do not function through any intermediary organ. If *testosterone* is applied to the skin of the face there is an immediate increase in the size and activity of the underlying sebaceous glands. This occurs before there could be any appreciable absorption of the hormone. On the other hand, if *estrogen* is directly applied to the face, the sebum secretion is reduced only after enough has been absorbed to affect other areas not locally treated. In other words, *androgens act directly* on sebaceous glands causing stimulation; and *estrogens* cause inhibition of sebaceous gland activity *indirectly*, probably through the reduction of the level of plasma testosterone. The latter effect requires tremendous doses of estrogen, whereas only small amounts of testosterone are needed to produce stimulation.

What are the sources of androgen in the female to account for sebaceous gland stimula-

* Read on May 19, 1965 at Atlantic City before the Dermatology Section of The Medical Society of New Jersey.

tion and the production of acne in girls? In the male, the sources of androgens are the testes and the adrenal. In the female, there is good evidence for ovarian, as well as adrenal, androgen in the female.

The question of the role of progesterone in sebaceous gland activity has stimulated the study of oral progestin-estrogen anovulatory drugs in the management of acne. Palitz[1] was the first investigator to report on the use of norethynodrel with mestranol (Enovid)® in the control of female acne. This was stimulated by the findings of Hasken, Lasher, and Rothman,[2] who injected large doses of progesterone into spayed female rats producing increase in sebaceous gland size. The androgenic effects of endogenous progesterone secreted in the luteinizing phase of the menstrual cycle could then, he reasoned, be a possible factor in acne of the female. If ovulation could be prevented and the corpus luteal progesterone secretion eliminated, acne might be helped. This he hoped to accomplish employing Enovid,® an anovulatory drug consisting of norethynodrel 10 milligrams plus mestranol 0.15 milligrams. He hoped to inhibit endogenous progesterone by using a synthetic progestin (norethynodrel), an agent with no androgenicity. Palitz[3] has also reported good to excellent results in 86 percent of acne in women treated with Enovid.®

Strauss and Pochi[4] have confirmed the effectiveness on sebum inhibition and acne of the use of cyclic progestin-estrogen in women. Their work was of significant interest in that they demonstrated quantitative gravimetric decrease in sebum production in 10 of 12 females who received norethynodrel with mestranol (Enovid)® cyclically. Up to 50 percent quantitative reductions in sebum elaboration was achieved in the course of 3 to 5 cycles of therapy. Morover, they were able to demonstrate by administration of norethynodrel and mestranol separately that the sebum inhibiting effect was primarily due to the estrogen mestranol. Similar suppression of sebum secretion occurred with combinations of norethindrone and mestranol (Norinyl).®

Thus, while confirming the observations of Palitz[3] regarding the beneficial effect of oral progestin-estrogen combinations in female acne, Strauss and Pochi[4] disproved the concept of Palitz[1] that they worked by eliminating endogenous progesterone. Moreover, Strauss and Kligman,[5] using gravimetric quantitative assays, showed that progesterone when administered in physiologic doses did *not* significantly increase sebum production. Strauss and Pochi[4] feel that sebaceous gland stimulation in the female is due in great part to the secretion of androgens from the ovary. They hypothesize that estrogen decreases sebaceous gland activity in the female by inhibiting ovarian androgens.

If the principle beneficial effect in sebum inhibition and acne control is primarily a function of the estrogen mestranol, what, if any, is the need for synthetic progestin? Why not use estrogen therapy alone?

In the past, estrogen therapy for acne in the female has been tried with equivocal results. In their review of the literature, Strauss and Pochi[4] found that the dosages of estrogen previously used have been (almost without exception) inadequate for reducing sebaceous gland activity. They quote the controlled studies of Torre and Klumpp,[6] who got satisfactory results in 37 of 42 persons treated with cyclic estrogen alone. Of those satisfactorily responding, 30 received a daily dose of at least 5 milligrams of conjugated estrogen (Premarin).® When such high doses of estrogen are used alone, Strauss and Pochi[4] found a high incidence of marked menstrual irregularities and menometrorrhagia. The great advantage, they say, of progestin-estrogen combinations in the treatment of acne is that significant sebaceous gland suppression can be achieved with the maintenance of regular menstrual periods.

The work of Paulsen, *et al.*,[7] lends more specific evidence for the adjunctive beneficial effect of progestin in these combinations. In 1962 they demonstrated inherent estrogenicity of the compounds norethindrone and norethynodrel. Bilateral gynecomastia was effected

in 11 of 12 normal male subjects after their administration of these compounds. Of 8 postmenopausal or surgically castrated women, 6 were relieved of symptoms of the climacteric, and breast engorgement was produced in all 8 with norethindrone and norethynodrel. So, it may very well be that the estrogenicity of the progestin may be additive to the mestranol in these compounds in inhibiting sebum secretion and acne.

Method

In our investigation, 20 females (ranging in age from 18 to 34) were treated cyclically with the oral anovulatory drug Norinyl,® a combination of norethindrone 2 milligrams and mestranol 0.1 milligrams. The duration of the acne ranged from 5 months to 20 years. In 14 (i.e., 70 percent) of the cases, the acne was rated as severe papular or cystic type. The remaining cases were rated as moderately severe.

Prior to the institution of oral progestin-estrogen combinations, patients were observed for a period of 2 to 3 months, during which time they had leveled off or relapsed from previous topical and/or oral antibiotic therapy. This was the extent of the control evaluation, since it was deemed impractical to do a double blind study with this kind of drug.

Patients were instructed to take one tablet of Norinyl® (norethindrone plus mestranol) nightly for 20 days, from the 5th to the 24th day, counting the first day of menstruation as day one. Two to four days following the completion of the cycle, withdrawal bleeding (pseudo-menses) occurs, and the therapy is resumed on the fifth day of the new cycle.

Follow-up examinations were done at two week intervals during the course of therapy. The duration of treatment ranged up to 6 months. Four patients did not complete the first cycle of therapy due to side effects which will be discussed later.

1 patient completed 1 cycle.
5 patients completed 2 cycles.
7 patients completed 3 cycles.
1 patient completed 4 cycles.
2 patients completed 6 cycles of therapy.

Results

Good to excellent results were obtained in 70 percent (14 of the 20). This was evaluated by a decrease in oiliness and disappearance of the papular and cystic lesions. Most of the women showing these results required at least 2 to 3 cycles of therapy. The initial improvement was invariably heralded by a diminution in the elaboration of sebum. One case was of particular interest. It was a 21-year-old girl with a severe acne of 3 years' duration who completely cleared after one cycle of therapy.

One patient, after having relapsed from 4 cycles of Enovid® therapy, was controlled with one cycle of Norinyl.® One patient showed additional improvement with Norinyl® after having been switched from 2 cycles of Enovid.® Two patients who were unable to tolerate Enovid® because of nausea and breakthrough bleeding responded well to Norinyl® therapy.

Side Effects

In appraising the side effects of the oral progestin-estrogen combinations, one should distinguish between minor physiologic effects and the severe effects sufficient to cause the doctor to discontinue therapy.

In this small series of 20 cases, 40 percent of the patients studied had side effects sufficiently troublesome to necessitate discontinuing therapy.

Three patients had severe nausea and vomiting, one of whom had, in addition, intense abdominal cramps.

Two patients had "break-through-bleeding," which was uncontrolled by doubling the dosage. One had associated abdominal cramps.

One patient refused to continue with therapy because of the scant menstrual flow.

One patient had marked breast tenderness sufficiently severe to discontinue treatment.

One patient developed an erythema multiforme-like eruption two days after onset of therapy. This cleared in a week after the treatment was terminated.

The observation of other workers as to side effects may be of interest. Strauss and Pochi[4]

found an incidence of 52 percent of patients on Enovid® showing some side effect, including nausea, break-through bleeding, weight gain, and the skipping of a period. They emphasize, however, that these were minor and in no instance necessitated the discontinuance of treatment.

In a series of over 200 cases treated with Enovid,® Palitz[3] reports side effects as follows:

1. Nausea—an initial morning nausea—occurred in about 20 per cent of the cases, which usually disappeared after one or two weeks. In only a few cases was nausea severe enough to discontinue therapy.

2. Distention of the breasts (and sometimes the abdomen) occurred in about 20 per cent of the cases. This, too, seemed to subside after several weeks.

3. Break-through bleeding occurred in about 20 percent of those treated during the first or second cycle. This was often controlled by increasing the dosage for a few days.

4. Chloasma has been reported by some as an occasional side effect.

Discussion

1. From the observations made in this brief experience with the use of the anovulatory combination Norinyl,® no broad conclusions are warranted.

2. While 70 percent of those treated were markedly benefited by the use of this progestin-estrogen combination, the high incidence of side effects sufficiently severe to warrant discontinuance of this drug would markedly limit its usefulness.

3. It is recommended that these anovulatory drugs be tried with discrimination *only* in the severe papular and cystic types of acne which have failed to respond to conventional topical and/or antibiotic therapy. Patients should be carefully chosen who are emotionally mature and who are willing to adhere to a regular regimen of treatment. They should understand that the tablets must be taken regularly, for 20 days; otherwise "break-through bleeding" or premature menstruation will occur. They must be willing to accept the fact that improvement may require as long as three cycles of therapy. They should be aware of the possible side effects of nausea, weight gain, and breast enlargement.

4. Many patients and their parents will recoil at the suggestion of any type of hormonal therapy in acne. In addition, the emotional or moral aspects of employing an oral contraceptive drug in unmarried young women will also limit the acceptance of this type of therapy in certain individuals.

5. It is *not* recommended that this therapy be pushed in individuals having such reservations.

Summary

1. Among 20 females treated cyclically with norethindrone and mestranol (Norinyl®), good to excellent results were obtained in 70 percent of the patients.

2. But 40 percent showed side effects sufficiently severe to warrant discontinuance of treatment.

3. Treatment with the oral progestin-estrogen combinations at this time should be reserved for females with severe papular or cystic acne unresponsive to conventional topical and/or antibiotic therapy. They should be emotionally mature and understand the limitations and possible side effects.

4. We can look forward in the future to the development and investigation of newer synthetic hormonal preparations such as these, which will attack the fundamental endocrinopathy in acne and hopefully limit the adverse side effects.

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40 Union Avenue

STATE ACTIVITIES

Trustees' Minutes

September 19, 1965

A regular meeting of the Board of Trustees was held on Sunday, September 19, 1965, at the Executive Offices. For the further information of the membership, more detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Blue Cross Rate . . . Noted that President John Bedrick has been appointed by the Governor to a special committee to investigate New Jersey's spiraling Blue Cross hospital insurance rates.

AMA Special Session . . . Approved the following report from actions by President Bedrick in connection with a petition for a special session of the AMA House of Delegates:

The Vice President of the Los Angeles County Medical Association communicated with all delegates to the AMA urging their support of a petition for a special session of the House to begin to formulate a definite official policy for the Association in regard to implementation of the "Medicare" law.

The following telegram was sent to the New Jersey delegates by the President:

A group of county medical societies is asking AMA delegates to sign a petition for a special AMA House session on October 2. Request is made that no New Jersey AMA Delegate comply unless asked to do so by The Medical Society of New Jersey.

The New Jersey delegates complied with this request. However, 37 delegates from 18 constituent associations signed the petition and the special session has been called for October 2 and 3.

In comments before the Bergen County Medical Society last week, Dr. Howard complimented the New Jersey action and expressed the wish that other states had done the same.

Physical Therapists . . . Approved the request of Health Commissioner Roscoe Kandle to cooperate with the State Department of Health in sponsoring a refresher course for physical therapists on inactive status.

Academy of Medicine . . . Voted *not* to co-sponsor with the Academy of Medicine of New Jersey a colloquium on "Planning for Future Medical Care," in accordance with MSNJ policy "not to con-sponsor programs in which MSNJ does not have an official voice in the planning and formulation."

Nursing Home Care . . . Authorized Dr. David Eckstein of Trenton (Chairman of the New Jersey Joint Council to Improve the Health Care of the Aged) to attend a regional institute on nursing home care, to be held in Philadelphia in October, dealing with the role of nursing homes under the Medicare Program.

Utilization Committees . . . Voted to inform the chairmen of all New Jersey hospital utilization committees about and to urge their attendance at an AMA-sponsored all-day session on "The Utilization Committee"—to explore the purposes, the philosophy, the mode of operation, and value of utilization committees; and to stimulate action programs at the local level.

Professional Liability Panel . . . Received the following report—and took the action indicated:

To bring the proposal into final completed form, as directed by the Board at its May meeting, the committee met on August 25. It reviewed the proposal as submitted to the 1965 House of Delegates, together with revisions suggested by the Committee on Medical Defense and Insurance, comments and suggestions received from 5 members, and the version approved by the Supreme Court on June 22, 1965.

The committee amended the proposal as submitted to the House of Delegates, and requested Mr. Backes to take the amended proposal to the Administrator of the Courts, Mr. McConnell, and obtain his reaction to it.

Mr. Backes reported that he had met with Mr. McConnell and his assistant who had suggested a few changes.

The Board reviewed the amended version as submitted by the committee and the changes suggested by the Administrator of the Courts. Following animated discussion, it developed that there were misunderstanding and dissatisfaction among the Board members as to precisely what was involved with relation to the favored situation of lawers under the program.

In view of the divergence of points of view, the Board directed that the proposal be returned to the committee, with the request that it come in with a recommendation as soon as possible, looking toward the possibility of having a special session of the House of Delegates later this year.

Annual Audit . . . Received the report of the Audit Review Committee, and approved the recommendations indicated:

1. It was noted that the surplus as of May 31 was $178,029.75. No recommendations were made because the Board will have use of this surplus for the Bicentennial Year.

2. It was found by the committee that after expenditures chargeable to budget operations for 1964-65, a $10,090.08 unexpended balance was realized.

3. The account of the Medical Student Loan Fund was discussed and it was agreed by the committee that some areas are not fully comprehended. It is recommended that the Board appoint a committee to sit with the members of the committee and re-establish regulations, study general management of the Medical Student Loan Fund, and outline the discretionary powers of the committee. It is further *recommended* that this report be submitted within three months.

4. The committee noted that the deficit in the Directory Reserve account was deleted by transferring a portion of unexpended funds in the 1964-65 Budget (approved by Board of Trustees on July 18, 1965).

5. The question of the review of the audit by MSNJ members was discussed. It was the general feeling of the committee that this audit is available for study by interested Officers and members of the Society, and that it would be an unnecessary expenditure of funds to publish the audit in The Journal or to mail it to the individual members.

Medical and X-Ray Technicians . . . Approved the following recommendations of the Council on Legislation, taken in conjunction with the Society-sponsored bill (S-179 of 1965) concerning medical and x-ray technicians:

1. That S-179 in its prseent form be permitted to "die" in the 1965 legislative session.

2. That early in the 1966 legislative session, an amended version of S-179 (which embodies amendments submitted by the Pharmaceutical Association) be reintroduced.

3. That MSNJ mount an all-out, concentrated campaign toward the successful enactment of this legislation.

4. That the Board of Trustees appoint a Task Force to decide upon and guide the procedures of a cooperative campaign—with MSNJ members, its Auxiliary, cooperating agencies, and para-medical personnel—to effectuate the passage of this legislation.

5. That the Task Force include the chairman of the Council on Legislation, one influential and active member from each judicial district, and the Legislative Analyst and Executive Director as consultants.

Disaster Medical Care . . . Received with appreciation a comprehensive report from Dr. Jack Karel, who attended as the Society's representative the AMA Civil Defense meeting in Washington; and noted Dr. Karel's comment that New Jersey ranks first in Civil Defense Region I Medical Self-Help Training Program.

Catastrophe Insurance . . . Adopted the recommendation of the Medical Defense and Insurance Committee that the "catastrophe" (or umbrella) policy proposed by American Mutual Liability Insurance Company be approved.

Bicentennial Scientific Program . . . Approved the following scientific program for the 1966 Annual Meeting:

The special committee appointed by the Board to develop the scientific program for the Bicentennial Day proposes a Symposium on gastro-intestinal bleeding, with Dr. Henry J. Tumen of Philadelphia, speaking on the medical approach; on the surgical approach, Dr. William S. Blakemore of Philadelphia, to speak on esophageal bleeding—Varices and Hiatal Hernia—and Dr. John L. Madden of New York on gastric and duodenal bleeding—Ulcers and Neoplasms.

President John Bedrick will serve as moderator.

Bicentennial Seal . . . Authorized the purchase of 50,000 bicentennial seals at a cost of $455.

Medical Care Programs . . . Directed that the component societies be informed of the resolution adopted by the American Medical Association urging medical societies to work toward the establishment of medical advisory committees—composed of representative practicing physicians in the state or community—to guide and advise state and local federal programs which relate to health care.

AMA Conference on Medicare . . . Authorized the President and Executive Director to attend the October 1 AMA Orientation Conference on Medicare.

AMA House of Delegates . . . Authorized the following to attend the Special October Session of the AMA House of Delegates, to consider pertinent items relating to current problems incident to health care laws and pending

legislation: President Bedrick; President-Elect Jehl; Executive Director Nevin; Delegates: Dr. Donnelly, Dr. Mulligan, Dr. Hughes, Dr. Patterson, Dr. Greifinger, Dr. Kustrup for Dr. Blaisdell, and Dr. Kaufman for Dr. McCall; and alternate Dr. Boylan.

AMA Clinical Convention . . . Authorized the following to attend the Clinical Convention in Philadelphia November 28 through December 1: President, President-Elect, Executive Director, regular delegates, and three alternate-delegates: Drs. Bowers, Kaufman, and Kustrup.

Medicine and Religion . . . Approved the program of the Woman's Auxiliary that—in each county in which the component society has established a committee on medicine and religion—a chairman on medicine and religion should be designated by the Woman's Auxiliary to cooperate with the Committee on Medicine and Religion of the component medical society.

Advertising Rates . . . Approved the recommendation of the Publication Committee that —effective immediately—THE JOURNAL accept 4-color process advertisements at the rate suggested by the State Medical Journal Advertising Bureau: 3 times the color rate, plus the regular base page rate.

Symposium on Defective Automobile Design . . . Accepted the invitation of the Essex County Medical Society to co-sponsor a symposium on defective automobile design to be held in Irvington on December 1, to promote both professional and public education in this area.

Medicare Fiscal Agent . . . Unanimously recorded itself as approving and urging the Medical-Surgical Plan of New Jersey (New Jersey Blue Shield Plan) to negotiate with the Department of Health, Education and Welfare for the purpose of being designated sole carrier for the State of New Jersey in the administration of Public Law 89-97 (89th Congress, H.R. 6675) Title XVIII, Part B—Supplementary Medical Insurance Benefits for the Aged.

Data Processing . . . Received the following report from the Executive Director and took the action indicated:

To obtain necessary statistical information on physicians in New Jersey, the New Jersey Health Facilities Planning Council will have the current Membership Directory information, with the exception of telephone number(s) and office hours, data processed. The Council offers to include this extra informational data at a service cost of $690. If the offer is accepted, this would enable MSNJ to employ data processing in the production of the 1966-67 Directory. Comparative figures between the actual cost of preparation and publication of the current Directory and the estimated preparation and data processing and publication of the 1966-67 Directory were presented and reviewed. It is estimated that there would be considerable saving by use of the data processing method.

The Board accepted the offer of the New Jersey Health Facilities Planning Council and approved the expenditure of $690.00, to be charged against the *Membership Directory* account.

The data processing proposal for preparation and publication of the next Directory was referred to the Special Committee on Membership Directory for consideration.

MSP Non-Participating Physicians . . . Noted the new policy of Medical-Surgical Plan on non-assignment payment to non-participating physicians, which became effective October 1, with the approval of the Commissioner of Banking and Insurance.

Medical Care in Project "Head Start"*

Thousands of physicians throughout our country took part last summer in medical aspects of Project Head Start, the "War on Poverty's" program for pre-school children from low-income families. In our own state, almost 12,000 children were enrolled in programs in 65 municipalities. More than 3,400 professional and volunteer workers carried out a unique program to help prepare these youngsters to enter local school systems this fall.

* By John C. Bullitt of Trenton, Director of the New Jersey Office of Economic Opportunity.

National statistics show that 90 percent of children of poor families entering public school have never had a physical examination. Fifty percent have no record of immunization against diphtheria or tetanus. Ten percent have hearing difficulties, and 4 percent are partly blind. At least 5 percent have nutritional deficiencies.

Head Start's medical program is geared to uncover significant defects and to plan for their prompt correction.

About one-third of the children from low-income families are poorly prepared for school. Without special help they are likely to fall behind their more fortunate classmates. Physical problems (such as visual or hearing defects) interfere with the ability of the child to understand his new experiences in school and make failure more likely. The early discovery and correction of such defects will increase the chance that these children will keep up with their school work.

Thus, the correction of physical defects was a logical place to start to help children from poor families.

Although a national committee offered guidance, the details of the medical programs of the 65 municipalities in New Jersey were determined locally so that they would fit the specific needs of the community. Our State Health Department and the New Jersey Office of Economic Opportunity offered consultation for planning and screening programs. They helped to work out ways to provide needed remedial services.

In most Head Start programs, the medical services included general physical examination and medical history, dental examination, vision screening, auditory screening, tuberculin skin testing, and immunization (for diphtheria, whooping cough, tetanus, poliomyelitis, smallpox, and measles).

As part of our nation's first major attack on the problem of poverty within our borders, Head Start represented an attempt to give pre-school; and the relative ineffectiveness of other to catch up with their contemporaries before first grade. This is expected to reduce the chances of school failure and of their becoming drop-out material.

Emphasis was put on health aspects of the program for three reasons: the known high incidence of physical defects found in underprivileged children; the recognized relationship between health problems and failure in school; and the relative ineffectiveness of other efforts to enlist the cooperation of poverty-stricken persons in health programs.

The examinations and screening procedures were done under a variety of circumstances. Some required considerable ingenuity. Most were carried out in school buildings or hospital clinics; but churches, private offices, and even private homes were also used.

In addition to the *content* of the medical programs much attention was given to its spirit. The need to make the physical examinations and other procedures as pleasant as possible was emphasized. Since this was the child's introduction to school, the importance of making this a warm experience was self-evident. It was considered essential that the health program must not detract from the total educational program. Thus, the general philosophy of the educational program was used throughout the health program.

Examinations were done singly, in privacy, and slowly enough so that the child could accept and understand the procedures. Parents were invited to be present to lend their support and to understand better the aims of the program.

The early years represent the critical epoch when the individual forms images of his expectations and hopes. For the child of poverty there are observable defects in his processes — many of them due to the child's inability to succeed in school. These defects lay the foundation for a pattern of failure and a pattern of poverty which persists for life. In a sense, the pre-school years afford important opportunities to break the poverty cycle.

The Head Start health program was a first step in this process. Even more important to the children involved will be the follow-up services to correct the defects found. This, of course, will depend on the cooperative efforts of physicians, nurses, social agencies, and medical care organizations in our communities.

New and continuing programs for the children of poverty are being planned. It will take all of our ingenuity and effort to overcome the handicaps of these youngsters. You, the physicians of New Jersey, will continue to play leading roles in planning for and providing these services.

More Efforts to Hamper Medical Research

Congressional hearings are underway on ten bills to interfere with the supply of laboratory animals. These ten bills have the ostensible objective of curbing pet stealing. They provide for licensing of both users and suppliers. They are distinct from the bevy of bills now before Congress to control the scientific use of animals within institutions. The first group of bills are S 2322, HR 9743, HR 9750, HR 9869, HR 9875, HR 10197, HR 10358, HR 10680, HR 10743, and HR 10745.

At the hearing on September 2, one proponent estimated the total number of animals used annually for scientific study in the United States at approximately 300,000,000. (That's what he said: 300 million!). Another insisted that 60 percent of all laboratory animals are stolen. Additional supporting testimony consisted of anonymous or nonspecific charges of misdeeds by animal users and suppliers.

No testimony was offered in support of the specific features of the bills.

Dr. George Wakerlin, Medical Director of the American Heart Association, summarized the case against the bills. He emphasized that the universities, hospitals, government laboratories, and individual scientists who must use animals in the solution of health problems have the biggest stake of anyone in legitimate dependable sources.

Despite agreement on stated objectives, Dr. Wakerlin and other spokesmen for scientific groups stated four objections to the particular approach to the problem employed by the pending bills. They are:

1. The proposed laws do not deal with the problem. On one hand they ignore most pet stealing. On the other hand, they ignore the affirmative needs for a legitimate supply of animals for health studies.

2. The bills are discriminatory, making pet stealing a Federal offense only when it is done by certain persons.

3. The bills are incongruous with existing Federal and state laws prohibiting larceny of all types, governing transportation of stolen goods, and receipt of stolen goods. The bills give jurisdiction by one federal department within the area of primary concern of another department.

4. The bills seem to be part of a larger pattern of effort to hamper health studies. Supporters of the bills who arranged the propaganda build-up and who testified for the bills have opposed the passage and complicated the operation of every law that provided affirmatively for the proper legally-supervised sources of needed animals.

Dr. Walter Booker, Chairman of the Washington Committee for Health and Research, told of efforts by the backers of the "anti-pet-stealing" bills to hamper operation of the law in the District of Columbia that saves for research use the unclaimed animals that would ordinarily be killed uselessly in the District pound. Dr. N. R. Brewer of the Illinois Society for Medical Research told of a highly publicized charge of cat stealing that evaporated when contested for want of a single prosecution witness.

Dr. Roger Estep, President of the National Capitol Area Branch of the Animal Care Panel, presented statistics on reported dog thefts, on impounded dogs, on dogs killed by motor vehicles and on dogs killed by public pounds and humane society shelters. He concluded that theft appears to be a tiny hazard compared to the others.

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of Filing: September 7, 1965.

2. Title of Publicotion: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

3. Frequency of Issue: Monthly.

4. Location of known office of publication: 315 West State Street, Trenton, New Jersey 08618.

5. Location of the headquarters or general offices of the publishers: 315 West State Street, Trenton, New Jersey 08618.

6. Names and addresses of publisher, editor, and managing editor: Publisher, The Medical Society of New Jersey, 315 West State Street, Trenton, N.J.; Editor, Henry A. Davidson, M.D., 315 West State Street, Trenton, N.J.; Asst. Editor, Miss Theresa E. Goeke, 315 West State Street, Trenton, N.J.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.): The Medicol Society of N. J., 315 West State Street, Trenton, New Jersey (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, and other securitv holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (if there are none, so state): None.

9. Paragraphs 7 ond 8 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in ony other fiduciary relation, the name of the person or corporation for whom such trustee is acting, also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner. Names and addresses of individuals who are stockholders of a corporation which itself is a stockholder or holder of bonds, mortgages or other securities of the publishing corporation have been included in paragraohs 7 and 8 when the interests of such individuals are equivalent to 1 percent or more of the total amount of the stock or securities of the publishing corporation.

10. This item must be completed for all publications exceot those which do not carry advertising other than the publisher's own and which are named in sections 132,231, 132,232, and 132,233, postal manual (Sections 4355a, 4355b, and 4356 of Title 39, United States Code).

	Average No. copies each issue during preceding 12 months	Single issue nearest to filing date
A. Total No. copies printed (Net Press Run)	7,842	7,850
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter soles		
2. Mail Subscriptions	7,409	7,428
C. Total Paid Circulation	7,409	7,428
D. Free Distribution (including samples) by mail, carrier or other means	337	334
E. Total Distribution (Sum of C and D)	7,746	7,762
F. Office use, left-over, unaccounted, spoiled after printing	96	88
G. Total (sum of E & F—should equal net press run shown in A)	7,842	7,850

I certify that the statements made by me above are correct and complete. Richard I. Nevin, Executive Director
The Medical Society af New Jersey

Social Security for You*

Social security protection is now for the first time provided for private practitioners and interns. Self-employment income from the practice of medicine will count toward social security benefits beginning with taxable years ening on or after December 31, 1965. Most of you will pay your first social security tax for the calendar year 1965. If you are on a fiscal year basis, these taxes will be paid for fiscal years ending in 1966. The earnings of hospital interns will be reported by the hospital unless the institution is exempt from social security coverage. Find this out from the hospital personnel office.

Social security is insurance against loss of income due to retirement, death, or disability. You pay into the social security trust fund through taxes and thus accumulate work credits which count toward benefits. A specified number of "credits" must be accumulated for benefits to be paid. The amount required is not less than a year and one-half nor more than ten years, depending on your date of birth, date of death, or date of onset of disability. The amount of the social security payment is directly related to your earnings over a specific period of time.

Right now, benefits are figured by using *all* earnings from the year 1951 to the year you become age 65 (62 for women), become disabled, or die. The five lowest years of earnings are dropped out in computing average earnings. Benefits may be lower for the first few years of coverage unless you received social security credit for work in some other capacity.

Retirement benefits can be paid at age 62 at a reduced amount; or at age 65 in the full amount. Retirement benefits become an annuity at age 72. At this age, you may collect regardless of the amount of your earnings.

Disability benefits are paid if a disability prevents you from engaging in your profession or any substantial work. You must have had five years of work under social security in the ten year period prior to the disability and also

* Prepared by Mr. Louis J. DeLucas, District Manager of the Social Security Administration at 437 East Hanover Street, Trenton 08608.

must have a disability that can be expected to last for at least 12 months.

Benefits can be paid to your family. Your wife can collect a benefit at age 65 or at age 62 at a reduced rate. If she is under 62, she can collect if she has children in her care who are getting benefits. The children can collect if they are unmarried and under 18, or if they are under 22 and attending school full time. A child can receive benefits after age 18 if he is unable to work because of a disability which began before age 18.

Survivor's or death benefits are paid to widows at age 62 or age 60 at a reduced rate. She can receive payments under age 60 under the same conditions as a wife under 62. The children can also collect under the same circumstances as under retirement and disability situtions. Dependent parents over 62 are entitled to survivors benefits if the parent has been receiving at least one half of his support from the deceased.

Social security is a vital part of family financial planning. Most insurance programs are built around the benefits you or your family would receive from social security. Although many of you cannot count on disability protection for five years, you can count on protection for your family in the event of your death as early as April, 1966. However, many of you have acquired social security credits through military service or as a result of being employed on salary as a company doctor, school doctor, and so on. All of these credits can be counted for social security benefits.

Those of you who are approaching 65 (or who are there already) will be interested to know that "retirement" has a statutory definition based on earnings and substantial services. All income from investments is excluded from these earnings. If you earn $1,500 or less in a calendar year, you are considered fully retired. If you earn over this amount, you will lose $1.00 of your benefit for every $2.00 you earn up to $2,700. Over $2,700 you will lose $1.00 of benefits for every $1.00 earned until the amount of your social security is exhausted. You may collect a benefit check for any calendar months that you do not render substantial services or earn over $125 regardless of your total earnings during the year. If you are in the habit of taking long vacations, look into this.

For physicians 72 years old or older, benefits may be payable as early as September, 1965 if they report earnings from self-employment for taxable years ending on or after December 31, 1965. This is a result of the recent change in the amount of social security "credit" required for people 72 or over to qualify for benefits. Minimum requirement is now 3 quarters of coverage for this group. If you are 72 or over and are not receiving social security benefits, you should check on this.

OBITUARY

Dr. Herschel S. Murphy

New Jersey medicine lost one of its pioneers and active participants on October 4, 1965 with the death that day of Herschel S. Murphy, M.D. He had been president of the Union County Medical Society and president-general of the National Order of the Sons of the American Revolution. Born in Texas in 1902, he received his M.D. at Jefferson in 1928. After completing an internship in his native state, he became a resident in obstetrics and gynecology at the Parkland Hospital in Dallas, and was chief resident in that specialty at Cornell University's medical center in New York City. Dr. Murphy decided to settle in New Jersey and went into the private practice of obstetrics and gynecology in Roselle. He became affiliated with the gynecologic and obstetric services at Elizabeth General, Rahway Memorial, and Newark Presbyterian Hospitals. He was active in the establishment of the American College of Obstetricians, and was listed as a Founder-Fellow of that organization. He was also a charter member of the New Jersey Obstetrical and Gynecologic Society.

BICENTENNALIA

"Dear Doctor Bones": John Cochran, Military Surgeon

Dr. John Cochran, a founder and third president of The Medical Society of New Jersey, was an eminent military surgeon during the Revolutionary War. Despite the hardships of this struggle, "Dear Doctor Bones" (as he was affectionately addressed in letters by Washington and Lafayette) was a favorite in the army because of his professional skill and convivial spirit. From a song he sang and from surviving anecdotes, we know that this sawbones brought out George Washington's rarely-shown sense of humor on at least one occasion. A letter inviting Mrs. Cochran to dine with him at Army Headquarters, West Point, in 1779, mentioned that wartime austerity proved that, lacking meat, anything—even apples—could be baked as pies and that one ate off iron rather than tin plates, but not because the labor of scouring made this transformation!

Born at Sadsbury, Chester Co., Pennsylvania, on September 1, 1730, of Scotch-Irish parents, John Cochran took his early schooling under the Rev. Dr. Francis Alison, a Presbyterian divine who subsequently became vice-provost of the College of Philadelphia (now the University of Pennsylvania). He was a schoolmate of Robert McKean, the latter a co-founder and first president of The Medical Society of New Jersey. Cochran studied "physic and surgery" as an apprentice to Dr. Thompson at Lancaster, Penna. During the French and Indian War (1754 to 1763) Dr. Cochran was a surgeon's mate with the British Army and saw action at Oswego and Fort Frontenac. In 1760 he married Gertrude Schuyler, widowed sister-in-law of General Philip Schuyler of Albany, N.Y.

Moving to New Brunswick, N.J., Dr. Cochran was among the seventeen original members of The Medical Society of New Jersey in 1766. Three years later he became its president and was reelected to that office in the following year. Volunteering for service at the outbreak of the Revolution, he collaborated with Dr. William Shippen, Jr., in preparing a plan for establishing military hospitals. In 1781, he succeeded him as Director General of the Hospital Department. Appointed Surgeon General of the Middle Department of the Continental Army in 1777, Cochran was commended by General Washington for his care of wounded and smallpox cases.

The war over, Dr. Cochran settled in New York, where, due to "a cheerful recollection of his past services," President Washington appointed him Commissioner of Loans (1790) with an office in Federal Hall. Retiring from this post to Schenectady, the doctor died there on April 6, 1807, following a paralytic stroke. Descendants of one of his three sons survive to this day.

Fred B. Rogers, M.D.

Cumberland County Medical Society*

On December 8, 1818, The Medical Society of New Jersey authorized the establishment of a "District Medical Society for Cumberland County." The charter members were Doctors Ebenezer Elmer (the first president); William B. Ewing (vice president); Enoch Fithian (secretary); and Doctors James Parvin, Charles Clark, Edmund Sheppard, Daniel C. Pierson, Isaac Hampton, and Lawrence Van Hook. A committee was appointed at this first meeting

* Prepared by Frank J. Aitken, M.D. Secretary

to draft rules for the government of the Society, and it was resolved that *any licensed practitioner attending the next meeting should be admitted as a member.* The subsequent meeting was held at Brewsters Hotel in Bridgeton on January 10, 1819. Here the bylaws were adopted, and 22 licensed doctors subscribed their names in the minute book—names even today made distinguished in this area by their owners.

Ebenezer Elmer, a scion of a distinguished medical family, studied medicine in 1774 in the office of his brother. In 1776 he served as an ensign and Surgeons' mate in the second Regiment of our Colony's Militia. He became Commanding Regimental Surgeon, serving until the disbanding of the army in 1783.

He was twice Speaker of New Jersey's Assembly. In 1800 he was elected to the National House of Representatives and for twelve years, he was one of our New Jersey Congressmen. He also served as a County Judge and as the Cumberland County Surrogate. One of his colleagues said of Ebenezer Elmer, "He has the courage to omit a prescription if it was not needed." Then, as now, that took real courage!

He reached the grand age of 91, and it was written that the organization of the Cumberland County Medical Society was due more to his influence and exertion than to that of any physician then living. He also established the first Sabbath School in Southern New Jersey and was, for many years, president of the Bible Society.

William B. Ewing was born on Dec. 12, 1776. He was graduated from Princeton in 1794. He "took medical lectures" under Doctors Rush, Shippen, and Wistar at the University of Pennsylvania. He practiced in the Virgin Islands for a few years and then returned to Greenwich, N.J., where he practiced until 1824 when he became President of The Medical Society of New Jersey.

From 1819 to 1832 he also served in the Legislature. He was a Cumberland County Freeholder for 21 years; a Judge of the Court of Common Pleas; and an active participant in framing our State's 1844 Constitution.

Enoch Fithian, like Dr. Elmer, came of a medical family which included Dr. Hosea Fithian and Dr. John Fithian, both distinguished South Jersey practitioners. He was one of New Jersey's earliest AMA delegates and served in that capacity for many years. He is chiefly remembered as the "reactivator" of organized medicine in Cumberland County. Between 1830 and 1840, our Society became inactive and its charter lapsed. It was Enoch Fithian who gave the sleeping organization the shot in the arm it needed. He headed the group that waited on the officers of The Medical Society of New Jersey asking for a new charter. It was granted, and Enoch Fithian was the first president of our County Society under its new charter.

In October 1873, Dr. B. R. Bateman offered the resolution:

> Resolved that this Society regard with peculiar pleasure at this meeting of our oldest and honorary member, Dr. Enoch Fithian, and hope that he may be honored many more times in the future.

On April 11, 1893, Dr. H. W. Elmer, secretary, announced the death of Dr. Enoch Fithian. This resolution was passed:

> The Medical Society of Cumberland County desires to place on record its high regard and esteem for one of its members, Enoch Fithian, who since our last meeting has been gathered to his fathers. His professional career was characterized by courteous bearing, sound judgment, and successful practice; and even when bowed down by the infirmities of age, the pleasantness of his manner, cordial greeting, and manifest interest in current events made his presence attractive and companionship desirable.
>
> Dr. Fithian died November 18, 1893 at the age of 100 years and 6 months. The Society has lost a father from its midst and an honorable member from its ranks.

These notes seem to be more biographic than "historical" in the traditional sense. This is because the history of any professional organization in its embryonic, highly individualized stages is, indeed, a narrative of its leaders. There are some less personal items that can be culled from our archives. Thus, a century ago our dues were $1.50 a year. We see that in

1848, Dr. Fithian presented "an interesting and instructive dissertation on epidemic bilious remittant of a high grade that in 'by-gone days' yearly scourged our County."

Thirty-seven members signed the "rules" at this meeting, an attendance better than some meetings today.

Early medical societies (especially in the first half of the 19th century) show much concern about fee schedules. In those days when medicine was acknowledged to be an art or a craft more than a science (a fact which is possibly true today but not so acknowledged), the Society was a sort of "guild." We see from an early 19th century Cumberland County fee schedule that "gonorrhea simplex, with attendance and medicine, was from $5 to $10 plus mileage;" and we learn that for a delivery, the fee was "$5 in a natural case, $6 for twins, and $10 in a preternatural case."

Let us hope that Blue Shield does not copy!

Monmouth County*

The earliest physician to practice in Monmouth County opened his office in 1734. Other doctors soon followed, some of whom were active in the formation of The Medical Society of New Jersey in 1764. In 1766, Nathaniel Scudder of Freehold was a pioneer in this enterprise.

The idea of a Monmouth County Medical Society was first discussed at a meeting of The Medical Society of New Jersey in New Brunswick in 1816. The proponents were Doctors Edward Taylor, William G. Reynolds, Samuel Forman, and Jacobus Hubbard, Jr. As a result of this and subsequent discussions, a constitution was adopted on April 24, 1820. Then they held two meetings a year, both in Freehold The first officers were: president, William G. Reynolds; vice-president, Edward Taylor; secretary, Samuel Forman; and treasurer, Jacobus Hubbard, Jr. The four founding members were thus the first officers.

The embryo society was plagued by poor attendance. A motion to establish a fine of $1 for non-attendance was defeated when first suggested in 1823; but was passed in 1825.

In addition to serving as a common meeting ground for its members, the Society also operated a medical library, which was surely one of the earliest professional libraries in the United States. In those days, medical texts and journals were scarce and expensive. The medical library soon developed large gaps in its shelves. The librarian reported in 1835 that many volumes had "vanished." All attempts to get them back were unavailing. The library was finally abandoned, and the remaining volumes were divided by lot among the members of the society.

The membership strongly supported the temperance movement. In 1835, the Monmouth County Medical Society resolved that "No wine bills shall be paid out of the funds of the society." A similar attempt to prohibit cigar smoking, however, failed. Up to 1884 the number of new doctors admitted to the Medical Society varied from none to 4 yearly. Total membership varied between 12 and 20. By 1893, our membership rolls had inched up to 36.†

Among the notable early practitioners was Dr. William A. Newell of Upper Freehold. He was elected to Congress, and it was he who led the fight to establish a life boat service along the coast of Long Island and New Jersey. Later, he became Governor of the Territory of Washington in the northwest.

Other noted practitioners of the early period included Doctors Arthur V. Conover, John P. Lewis, and Archibald Higgins. Dr. Conover (born in Manalapan in 1809) studied at Princeton University and the Duane Street Medical College in New York. He began practice 1829 and later served in the State Legisla-

* Prepared by Peter J. Guthorn, M.D.
† Today it is 352.

ture. He was, for several terms, Surrogate of Monmouth County. His two sons became prominent physicians, too.

Dr. Lewis was born in Navesink Highlands in 1788. He was educated in Nova Scotia and at the College of Physicians and Surgeons in New York. He started practice in Manasquan in 1811. It was related that once, called to reduce the dislocated jaw of a woman reputed to be a scold, he marked that it might be better to leave her jaw where it was. However, after exacting a promise of better conduct, he relented.

Dr. Archibald Higgins attended Pennington Seminary and completed his studies at Princeton in 1844. He then opened a grammar school in Burlington County but later turned to medicine. He was graduated from the University of Pennsylvania as an M.D. in 1854 and entered practice in Manasquan. He was also a school trustee, promoted the building and loan association, and worked for the extension of the turnpikes and railroads.

During the Civil War many Monmouth County men saw service. Among these was Dr. Henry C. Cooke of Holmdel, the son of a successful medical practitioner. He was graduated from Rutgers in 1853 and from the College of Physicians and Surgeons in 1857. He entered the Army as one of the New Jersey volunteers in 1862, serving until 1865. He then returned to his practice in Holmdel and soon became one of the premier surgeons in Monmouth County.

Bicentennial History

Publication of *The Healing Art*, a comprehensive one-volume history of The Medical Society of New Jersey (1766 to 1966), will document the two-hundredth anniversary of the nation's first state medical society. A book replete with human and professional interest, its title comes from the Centennial address by Dr. Abraham Coles, a prime poet-physician of the past century. Carefully prepared by Archivist-Historian Dr. Fred Rogers, with the collaboration of Mrs. Arlene R. Sayre, the chronicle will provide a readable keepsake as well as a factual compilation of 200 years of New Jersey medical and cultural history. This auspicious record, a book approximately 300 pages in length with 100 illustrations, will be made available to the Fellows and members of the Society, and to related professions and the general public as part of our Bicentennial observance.

Thanks are extended to all members of the 21 county medical societies who responded generously to the JOURNAL's repeated request for information during the past two years. From these sources came valuable primary material, documents, and photographs to enhance the text and illustrate the progress of medicine since the Society was founded in 1766.

The history has had the expert attention of the members of the Special Committee on Bicentennial History, working with the Archivist-Historian. They are: Dr. Emanuel M. Satulsky, Chairman (who is also Secretary of the Board of Trustees), Dr. Samuel J. Lloyd, Dr. George B. Sharbaugh (who is also Chairman of the Publication Committee), and Mr. Richard I. Nevin Executive Director. To Board of Trustees representative Dr. Lloyd, and to Mr. Nevin and his staff members, Mrs. Edith L. Madden and Miss Theresa E. Goeke, special gratitude is expressed for critical reading and technical assistance. The book will be printed by the same firm that does the excellent job each month in producing the JOURNAL.

With such quality of assistance and the cooperative interest of others, all augers well for a superb compilation to be available for the 200th birthday celebration of The Medical Society of New Jersey in Atlantic City, May 14 to 18, 1966.

ANNOUNCEMENTS

Psychoanalytic Meeting

An open scientific meeting of the New Jersey Psychoanalytic Society will be held at the Hackensack General Hospital on Friday, November 12, at 8:00 p.m. *Subject:* "A Form of Serendipity in Patients with High I.Q." The essayist will be Sylvan Keiser, M.D. Discussion will be opened by Howard H. Schlossman, M.D. and Henry Z. Shelton, M.D.

Multiple Sclerosis Meeting

On Thursday evening, November 18, there will be a discussion of "Research and Treatment in Multiple Sclerosis." This meeting will start at 8 p.m. in the Lawrence Junior High School at Gedney Road (at Princeton Pike) in Trenton. The sponsoring agency is the Mercer County Medical Society and the meeting is under the auspices of the Central New Jersey Chapter of the National Multiple Sclerosis Society. There is no admission charge. For more information, write to Multiple Sclerosis Society at 48 North Overbrook Avenue, Trenton 08618.

Malignancy in Childhood

A paper on the chemotherapy of childhood malignancies will feature the Wednesday evening meeting of the pediatric section of our state's Academy of Medicine. This will start at 9 p.m., December 1, at the Rahway Hospital on Jefferson Avenue in Rahway. (Parkway exit 135). The essayist will be Harold Dargeon, M.D. of New York's Memorial Hospital.

Your Responsibility for Sex Education

All afternoon, Wednesday, December 1, there will be a symposium on the physician's role in sex education. Held under the auspices of the New Jersey Academy of Medicine (and supported by a grant from Ortho), the colloquium will be at the Essex House, 1050 Broad Street in Newark. Members of the Academy, nurses, interns, and residents will be admitted without fee; for others, the registration is $4. The speakers include Dr. Milton Levine and Mary S. Calderone. The final paper, entitled "The Rapid Treatment of Sexual Inadequacy," is being given jointly by Virginia Johnson and William H. Masters, directors of the Reproductive Research Foundation of St. Louis.

Diabetes Symposium

On Wednesday, December 1, 1965, the State Health Department in conjunction with the N. J. Diabetes Association will present its ever-popular annual colloquium. This year's *topic:* complications of diabetes. The *place:* Prudential Plaza Building in Newark. The *time:* starts at 2 p.m., ends at 5 p.m. The *speakers:* Doctors Harold Rifkin, Joseph Morse, John Bookman, and Morton Bryer. You are invited. For more details, write to Arthur Krosnick, M.D. of our State Health Department at P. O. Box 1540, Trenton 08625.

Institute On Retardation

The Annual Johnstone Institute will be held this year on Friday, December 10. The theme will be "Manpower and the Rehabilitation of the Retarded". The institute is held at the E. R. Johnstone Center in Bordentown, time not stated. For information, write to Dr. Joseph Parnicky, Johnstone Training Center, Bordentown, New Jersey.

The Fifty-Year Club

Here's one club you can't buy your way into: the Fifty-Year Club. To be eligible you must have been practicing medicine for 50 years or more. The first president was Walter C. Alvarez. It's a club of men who have had a sense of meaning in their lives and who don't want to be counted out or classed as trivial. For more details, write to the secretary: Dr. J. McCurry, Cash, Arkansas 72421.

Contact Lens Course

Now available is a unique course in contact lens fitting. The tuition fee is $75 (half-price for residents) and the course is scheduled for March 12 and 13, 1966. Mr. Frederick Ridley of London (England) and Dr. Jorge Buxton (of the New York Eye and Ear Infirmary) are the instructors. The course is given at the Eye and Ear Infirmary at 218 Second Avenue, New York. Inquiries should be directed to "The Registrar" at that address, New York City 10003.

New Seminar in Ophthalmology

The distinguished Swiss ophthalmologist, Rudolf Witmer, M.D., is coming to New York in March 1966 and will deliver five lectures from March 28 to April 1, 1966. He will discuss retinal degeneration, retinal detachment, and uveitis. For full program, write to Registrar, Institute of Ophthalmology, 218 Second Avenue, New York, New York 10003.

New Weight Control Record Chart

Now being sold at one dollar ($1) is a unique weight record form and control chart, developed by a group of physicians and dietetians. It uses a vertical scale which sharply indicates any rise or fall of poundage. It also shows the gain or loss trends, rather than just the daily fluctuations. On the chart is a "caution zone," shaded in green to cheer dieters as they come near their ideal weight and also to warn them rapidly of any gains, should they start to gain after attaining this weight.

Space is provided to record losses or gains over a four months' period. Printed on a cheerful yellow, durable glossy stock, the chart has adhesive backing so that it may be fastened to the back of the medicine cabinet mirror, closet door, or wherever the scales are located. Complete use instructions and height-weight charts for men and women are printed on the back.

Charts are available by mail from the Scott Corporation, 1410 N. E. Marine Drive, Portland, Oregon.

Health Care in Scandinavia

The four Scandinavian countries have, for a century, had nationwide health insurance plans. Many American observers have characterized Sweden and the other three Nordic nations as practitioners of a "middle way." Others, while conceding that medical and hospital standards in Scandinavia are enviably high, have suggested that the same system would not work in a huge, heterogeneous nation like the USA. Most American physicians have little familiarity with the subject.

The *Scandinavian Times,* a "newsmagazine" (in English), has (in its May 1965 issue) a six-page section called "Health Care for All." Written by the well known American-medical news writer, Fradley H. Garner, this gives a brief but adequately detailed account of the workings of the Scandinavian medical care system.

For a reprint of this section, write to P.O. Box 439, Peter Stuyvesant Station, New York 10009.

Poisonings in New Jersey: 1964

Of New Jersey's 40 Poison Control Centers, 37 reported accidental poisonings in 1964 to the State Health Department. A total of 3713 accidental poisonings were listed for 1964. West Jersey Hospital in Camden reported the largest number: 321. Next was Fitkin Memorial Hospital in Neptune, with 238 cases. A total of 16 centers reported between 100 and 200 cases. Two centers reported less than 10 cases.

Of the 37 reporting centers, 17 cooperated in having home followup investigations done on the poisonings. This aggregated 821 such investigations. Most follow-ups were done on the poisonings reported by Mountainside Hospital, Montclair. They did 116 out of a 130 reported poisonings. A total of 6 centers had between 50 and 100 follow-ups done.

BOOK REVIEWS

Dorland's Illustrated Medical Dictionary. Ed. 24. Philadelphia, 1965, Saunders. Pp. 1724. ($13; deluxe edition $17).

Like good wine, this superb dictionary needs no praise from any reviewer. A new section, fundamentals of medical etymology, adds another dimension. The definitions are concise and vivid. Tabulations range from cavity angles of teeth to listing of poisonous snakes, and enhance the usefulness of the text. There are other good medical dictionaries, of course; but for all in all excellence, *Dorland* is still the yardstick.

HENRY A. DAVIDSON, M.D.

Modern Treatment: (I) Renal Disease: (II) Thyroid Disease. Edited by E. L. Becker, M.D. and Edward Carr, M.D. New York, 1964, Hoeber. Paperback. The first of a six-times-a-year series. ($16 for the six books annually.)

To keep abreast of the rapidly moving front of medical treatment, Harper and Row (through its Hoeber Medical Division) is issuing six paper-backs a year on modern therapy. Each volume will consist of a symposium on one or two areas of current medical interest. The series will carry no advertising. Each section of this opening volume has chapters written by experts. Emphasis is on practical treatment measures. The publishers will not, however, sell individual copies. You must subscribe to all six volumes (at $16) for the year. Already announced are symposia on anemia, liver disease, epilepsy, and cardiac arrhythmias.

VICTOR HUBERMAN, M.D.

Activities of Surgical Consultants. Volume II. Edited by B. Noland Carter, M.D. Washington, 1964, Department of the Army. Pp. 1,100, illustrated. ($8.50)

Volume II, Activities of Surgical Consultants, World War II, is up to the standards set by the first volume and in many ways even excels. The art work, layouts, illustrations, and printing in this volume are especially commendable. The biographic material of the authors and their activities are well outlined for posterity.

At the beginning of the war, the duties of the consultants were not clearly understood, and there was confusion as to how they should function. There was no precedent for the status of surgical consultant to an army, and members of the consultant staffs were feeling their way at the beginning. Some question arises when statements like those are encountered on page 349 from the chief surgeon in the European Theatre: "The American soldier, in my considered opinion, has received better care than he has ever received in his life, in former wars or in our civilian life. There is only one reason for this: because this consultant group has completely directed and administered the care of the soldier. To them, all credit for this is due." I do not believe the rank and file of the medical officers working in the field would appreciate this comment.

The material applying to the Pacific Theatre and Asia is especially commendable. From the reports sent to the Surgeon General's office from consultants in this area, it would appear that supplies and equipment were the major source of concern. It is difficult to see why this duty should devolve on the consultant. It would seem that each hospital Commanding Officer must have been acutely aware of this situation.

I found the dairies on the visits to the hospital particularly illuminating and the comments on the individual hospital in this area were clear cut and pertinent.

D. F. FEATHERSTON, M.D.

The Children's Bookshelf. A guide to books for and about children prepared by the Child Study Association. New York, 1965, Bantam Books. (soft cover) Pp. 194. Second Edition. ($0.95)

This new edition of this well-known guide will be welcomed by all who have worked with or are charmed by children. The first section includes a warm, practical treatise on how to read to a child. There is interesting material on children's tastes in reading, on Mother Goose, on poetry as a means of enchantment, on developing the child's own library, and on the case for fairy tales. The suggestions are sensible, free of cant, and devoid of any know-it-all preaching. There is no assumption that a book creates an interest: but a lot of sage advice as to how to use books to develop an interest.

Another section deals with books for parents. It includes a wise and witty chapter on what parents can—and cannot—learn from reading. This is followed by book lists grouped under such headings as books about the family, childhood, schools, religion, ethics, sex education, recreation disabilities, and the like. The backbone of this text, however, is the children's reading list divided first into age groups, and then into subtopics such as fantasy, folk tales, sciences, history, nonsense, fiction, and so on. A remarkably compact one-line review is affixed to each title. A publisher's directory and an exhaustive 30-page index complete this meaty little volume. To any person who works with children professionally, this paperback will prove as useful as his telephone directory—and a lot more interesting. Better get two copies: if you are at all busy, you'll wear the covers off one in a few months.

RALPH NEIL SHAPIRO, M.D.

Juvenile Diabetes: Adjustment and Emotional Problems. Edited by T. S. Danowski, M.D., Arthur Krosnick, M.D., and Harvey C. Knowles, Jr., M.D. Proceedings of a workshop held in Princeton in 1963. Pp. 151.

The main thesis of these proceedings is that there are emotional and adjustment problems peculiar to diabetics. The thesis is pursued with variable success through a bewildering series of ramifications which are not always pertinent to the main theme. On the whole, federal and local northeastern medical and sociological centers have supplied a very distinguished group of contributors. Dr. Danowski's essays in particular give coherence to the work.

The lack of adequate statistics on the number of children with problems is mentioned. One portion of the discussion deals with the relationship of the age of onset to the type of problem, and passing references are made to the diabetic camp as a solution. The panels discuss iatrogenic factors and make suggestions for the elimination of them as causes of the problems. School situations and the attitude of personnel connected with the school systems comprise parts of one of the workshops. One discussion includes variants of the initial reactions to the discovery of the diabetes by the child

and the parents. These are just a few of the wide list of subjects often only briefly mentioned.

The very format of the summary of a "workshop" has in it the inherent characteristics of sketchy and sometimes redundant and irrelevant material. Dr. Danowski makes a plea for more study data and points out the greater number of questions than answers now available. The food for thought offered for the reader of this pioneering study compensates for the apparent disorganization. The extremely wide scope and critical discussion serve as a loose framwork of reference for all those interested in the problems of the juvenile diabetic.

EVERETT O. BAUMAN, M.D.

Handbook of Pharmacology. W. S. Cutting, M.D. Ed. 2 New York, 1964, Appleton-Century-Crofts. Pp. 647, Softback ($5.95)

This text reviews the compactly background knowledge of each topic. Dr. Cutting has also included information that is new and pertinent. He has stressed the mechanisms of action of new drugs and new members of older groups of drugs. Structural formulas are listed, thus enabling the reader to place a new drug swiftly into a familiar group. The handbook is arranged into three main parts: chemotherapeutic agents, somatic agents, and nervous system agents. The index lists the drugs alphabetically. The writer describes the older drugs of each group, first in his text and then follows with the newer ones.

This handbook is of value in orienting students to larger textbooks of pharmacology. It gives the practicing physician a handy summary to supplement his knowledge of clinical pharmacology. I am sure that the text will be of value as an epitome of new drugs for medical students, research workers and clinicians.

HAROLD S. FELDMAN, M.D.

Clinical Haematology In Medical Practice. G. C. de Gruchy, M.D. Philadelphia, 1964, Davis. 681 Pp, 74 illus., Second Edition ($12.50)

This book deserves to be better known among American physicians. Written by an Australian hematologist, it is a masterpiece of clarity and organization. Among the sections of special merit are those on interpretation of marrow morphology, differential diagnosis of anemia and pancytopenia, and the numerous comparative tables. On the other hand, a few important details are lacking. An example is the range of dosage of radiation used in therapy of lymphomas. Hemoglobin C disease should be added to the list of nonsideropenic hypochromic anemias. The management of hemolytic transfusion reactions omits newer measures such as mannitol diuresis, potassium-removing resins, and peritoneal dialysis. There is but passing reference to disorders of iron storage.

Illustrations are comparatively few in number. Those present are well-prepared and useful. One looks in vain for diagrams of the technic of marrow aspiration, or for structural formulae. Future editions will doubtless be enhanced by additional illustrations. On the other hand, the author was wise not to include the familiar color plates of blood dyscrasias which would have driven the cost of the book beyond the present modest figure.

This well-organized and clearly written short textbook of hematology is highly recommended for students, teachers, and practitioners alike.

HARVEY ROTHBERG, M.D.

Bahama International Conference On Burns. Philadelphia, Dorrance, 1964. Pp. 209, illustrated. ($12.50)

A conference on burns was sponsored by the Colonial Research Institute at Grand Bahama last March. Many authorities from Europe and America contributed to this text. Highlights of the symposium were a paper on pulmonary complication by Phillips of Boston, a treatise on surgical treatment by Skoog of Sweden, a unique contribution by Amos of North Carolina on genetics and immunologic factors in skin graft rejection, and the pioneer work on capillary permeability by Arturson of Sweden. Of interest was the presentation of the "Hovercraft" principle in the treatment of circumferential burns by Watts of England. Lack of illustrations made this incomplete.

In the discussions about the fluid replacement, I feel it a "miss" that Eagle's solution was not mentioned. Pulaski (Walter Reed Army Medical Center) gives his usual thorough review on the infection problems. At the time of the conference, Feller's pseudomonas antiserum was not known yet.

The paper by Luccioni of France reflects general interest in the use of oxygen as a therapeutic agent. This interest existed in Europe for years and only now is finding its way into the United States.

Each chapter is followed by a discussion by all participants, which increases this book's value.

ROBBY MEIJER, M.D.

Blood Program In World War II. Brigadier Gen. Douglas B. Kendrick, MC, USA. Washington, D.C., 1964, U.S. Government Printing Office, Department of the Army. Pp. 922, illustrated. ($8.00)

This is a thoroughly documented historical account of the development of military blood transfusion and blood banking between 1917 and 1957. While it concerns itself primarily with Army activities, it has lessons for all blood services.

Experiences in the organization of blood donor programs, blood collections, technics of blood testing, processing, and administration are specifically outlined under both optimal and field conditions. Surprisingly well covered are the problems of the use and limitations of blood substitutes and blood fractions.

While considerable progress has been made on this subject since 1957, the volume nevertheless serves a useful role in describing an adequate approach to further development of both the problems of blood transfusion.

LESTER M. GOLDMAN, M.D.

Corneal Contact Lenses. Edited by Louis J. Girard, M.D. St. Louis, 1964, Mosby. Pp. 342, with 342 illustrations. ($19.75)

This book belongs in the office of every ophthalmologist who does, or who anticipates doing, contact lens fitting. It is an excellent handbook and reference for all contact lens problems. It includes numerous diagrams, tables, charts, and photographs—all of which beautifully supplement the text. The reader is guided carefully by the hand through all the steps of contact lens fitting. The text is written on the assumption that the reader is a complete neophyte in contact lens work.

The explanation of optical principles—a difficult presentation at best—is handled with clarity and lucidity, with many diagrams to refresh the memory. On the

indications for prescribing lenses, examination of the patient, and use of the keratometer, the writing is orderly and clear.

The section on the manufacture, design, and modification of lenses will be of particular interest to the ophthalmologist who works with a technician in his office, equipped to make those changes on the spot.

This book covers not only the usual contact lens problems, but also reviews the special cases of aphakia, keratoconus, and bifocal lenses. Contact lens fitting is a medical problem, and the eye physician would do well to absorb the information between the covers of this excellent text. S. Jerome Greenfield, M.D.

Psychoanalysis and the Human Situation. Jessie Marmorston, M.D. and Edward Stainbrook, Ph.D., M.D. New York City, 1964, Vantage Press, Inc. Pp. 270.

This collection of papers was written to commemorate the 70th birthday of Franz Alexander. The first three articles are laudatory presentations of Alexander's life which, it appears to this reviewer, suggest that the authors have been carried away by their enthusiasm.

The one article by Dr. Alexander takes a compromising position regarding the relationship between psychoanalysis and medical treatment. The result is that he both agrees and disagrees with Dr. Thomas Szasz's position "which deny to mental illness the quality of illness."

Myerhoff, a Professor of Philosophy, deals with the relationship between psychoanalysis and history, while Strupp, an Associate Professor of Psychology, deals with the problem of evaluating the results of psychotherapy. Papers by Edith Weigert, Leon J. Saul and Roy Grinker are concerned with "Psychoanalysis, A Method of Re-education," "On the Causes and Treatment of Emotional Disorders," and "Psychoanalytic Theory and Psychosomatic Research" respectively. The book concludes with a summary of the remarks made by the five participants in a panel discussion on "Psychoanalysis and Medical Education."

The two basic themes that run throughout the book are (1) psychoanalysis and psychotherapy are essentially processes of reeducation and (2) the psychoanalytic movement has become rigid, uniform, and too regulated so that it threatens individual creativity. These are interesting, if poorly supported, ideas. The articles contribute little to the analytic literature.

Stanley R. Kern, M.D.

The Visual Fields. A textbook and atlas of perimetry. St. Louis, 1964, Mosby. 2nd Edition, Pp. 386. ($16.00)

The development of new peri- and campimetric technics and the modification of the old ones made the second edition of this book a welcome and necessary project.

The first edition enjoyed worldwide acceptance. The second edition is the most comprehensive and up-to-date work of this kind. Several chapters were rewritten and new illustrations have been added. The experimental objective electric perimetry, "the instrument of the future," is described. Chapters on glaucoma and special perimetric technics provide more understanding of the problems involved than in the previous edition. This well-written book is complete in theoretic considerations without sacrificing the practical need of clinicians. Detailed case reports, confirmed by surgical or autopsy findings, make the illustrations more authentic.

A good index helps locate illustrations of field defects in various conditions. This is a useful text or reference book, or atlas for visual field studies. A good companion for ophthalmologists and neuro-surgeons.

Bela Szinegh, M.D.

Fundamentals of Orthopaedics. By John J. Gartland, M.D. Philadelphia, 1965, Saunders. Pp. 338, illustrated. ($8.00)

The author scores a bulls-eye! His aim is to acquaint the student with the specialty of orthopedic surgery and this he does. The book is easy to read and well laid out. After the student reads it, he will be impressed by the variety of problems that the practicing orthopedic surgeon can encounter. If he is inclined toward research, Dr. Gartland stimulates this appetite in the last chapter.

Since this is a book for students, I have three criticisms. First, the author might emphasize (with italics) that open reduction does *not* make a fracture heal faster but rather that it is used to maintain a reduction that cannot be held by closed methods.

Second, I think Dr. Gartland is wrong in stating that "internal fixation is not widely employed in compound fractures."

Third, when listing the causes of non-union of fractures, I think he should have stressed inadequate immobilization and infection to point up the leading causes of non-union.

These suggestions would improve an otherwise well done book. Gerald E. Rubacky, M.D.

Heart Attack: New Hope, New Knowledge, New Life. By Myron Prinzmetal, M.D. New York, 1965, Simon and Schuster. Pp. 232, illustrated. ($1.75 paperback)

Paul Dudley White's bicycle riding to prevent coronary attacks initiated a trend now becoming as fashionable as fat restriction. Dr. Prinzmetal, collaborating with a patient, William Winter, carries forward both these concepts as if these were the ultimate panacea. They make their point. Exercise and fat restriction are good for the prevention of the first coronary as well as for the subsequent one. Nor do they neglect to mention reduction of obesity, management of tension and anxieties, and prohibition of smoking.

These are all nicely laid out in a quickly readable paperback beamed at lay audiences. About a third of this text is devoted to low-fat sample menus and recipes ranging from a 600 calorie diet to an 1800 calorie one.

In spite of the important restrictions in diet and smoking, the theme of the author is definitely one of hope and permissiveness. "Live to Your Hearts Content," they title one of their chapters. And indeed, they approve of rapid return to all normal activities following an attack and emphasize a daily 5 mile walk. To one frequently asked question, they summarize the answer in the title of a chapter: "Sex? Of Course!"

The inquisitive post-coronary will like the frank and enlightening discussion of his disease presented in this book. Harvey Nussbaum, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

NOVEMBER, 1965 • VOL. XXXVIII, NO. 9

RHEUMATOID LUNG DISEASE

Among a large series of cases of rheumatoid arthritis, nine patients had diffuse pulmonary fibrosis. Pleuritis was the most common pulmonary lesion and dyspnea on exertion was an early clinical feature. Clubbing of the fingers and subcutaneous nodules were frequent, too.

Rheumatoid arthritis is a systemic disease characterized by pain and disability in peripheral joints. The disease may affect any organ but exhibits a strong preference for tissues abundant in mucopolysaccharide such as the joints and other serous surfaces, the eye, and the arteries.

The most typical histologic lesion is the necrobiotic granuloma. This histologic lesion is not completely specific, but is usually considered diagnostic of rheumatoid arthritis if the clinical manifestations of the illness are present.

An association observed between rheumatoid arthritis and lung disease has given rise to the term rheumatoid lung disease, but there is no well-defined concept of the relationship. The present study was undertaken to clarify this relationship.

Nine Cases Studied

Hospital records were reviewed of 702 patients diagnosed as having rheumatoid arthritis between 1950 and 1963 at the University of Arkansas Medical Center and Little Rock Consolidated Veterans Administration Hospital.

Patients were included in the study only if the roentgenogram showed moderate or severe diffuse pulmonary fibrosis. Of the 702 rheumatoid arthritis patients, diffuse fibrosis appeared in eight. A case from another hospital was added, to make nine in all. Subcutaneous nodules occurred in six of the patients, usually about the elbows and wrists.

Arthritis usually preceded the development of the pulmonary lesion. The interval between onset of arthritis and onset of pulmonary lesions ranged from 2 to 10 years in five patients. As for the other patients, respiratory symptoms were not present in two at the time chest abnormalities were discovered, and one patient developed pulmonary symptoms eight years prior to the onset of arthritis. There was no correlation between the severity of arthritis and the severity of pulmonary fibrosis. Four of the patients had severe crippling deformity of peripheral joints, two had moderate deformity, and three had mild deformities limited to the joints of the hands and wrists.

On the basis of chest roentgenograms, the fibrotic lesions in the lungs remained constant or increased in severity in all patients. There was no evidence that the infiltrative lesions ever regressed or that therapy altered the course of the pulmonary disease.

Results of pulmonary function studies were typical of cases of diffuse pulmonary fibrosis. The vital capacity was reduced; expiratory flow rates were normal.

The most common pulmonary lesion is pleuritis. It may occur without symptoms or be

C. Dowell Patterson, M.D.; William E. Harville, M.D.; and John A. Pierce, M.D.; *Annals of Internal Medicine,* April, 1965.

accompanied by pain in the chest. Although it often passes unnoticed, pleural effusion is frequently associated with pleuritis and may be detected if roentgenographic examination of the chest is done at the proper time. The episodes of pleuritis tend to be mild and transient, although they may be severe, but in either event the result is fibrosis. Postmortem examinations often reveal dense pleural adhesions consisting of fibrous tissue without specific changes. The pleura, however, may contain typical rheumatoid granulomas with a central zone of fibrinoid necrosis surrounded by a fibrous layer of palisading connective-tissue cells and scattered mononuclear cells.

Histologic Changes

Interstitial pneumonitis tends to appear diffusely throughout the lung but may occur only in localized areas about the bronchi and blood vessels. The initial histologic event is dense lymphocytic infiltration with edema and thickening of the interalveolar septa. Lymphocytic foci resembling germinal follicles may be prominent, and the alveolar epithelium may be cuboidal. There is usually no intraalveolar exudate.

The clinical features in pulmonary fibrosis include the early appearance of dyspnea on exertion. Recurrent bronchitis with cough and sputum production and clubbing of the fingers are both common. Subcutaneous nodules are especially frequent, fine crackling rales are often heard, and cor pulmonale sometimes develops. Any degree of joint disability may occur. Total lung capacity is decreased because diffuse thickening of the alveolar walls alters the elastic properties of the lung. The resistance to expiratory air flow is usually normal but may be increased if the patient develops bronchitis or honeycomb lung. Otherwise, the physiological features are those of any sort of impaired diffusion or defective gas transfer.

Two types of pulmonary fibrosis occur in patients with rheumatoid disease—diffusely nodular and coarsely nodular. Necrobiotic granulomas are more common in coarsely nodular fibrosis but may occur in diffuse fibrosis as well. Not only do histologically typical rheumatoid granulomas appear deep in the lung parenchyma, but lymphocytic foci with dividing lymphoblasts occur which simulate germinal follicles. These findings are helpful in the differentiation of rheumatoid disease from other types of diffuse pulmonary fibrosis.

The central issue is whether the rheumatoid process results in lung disease in the absence of other pathogenic stimuli or the pathologic changes occur because the lung tissue is more reactive than usual.

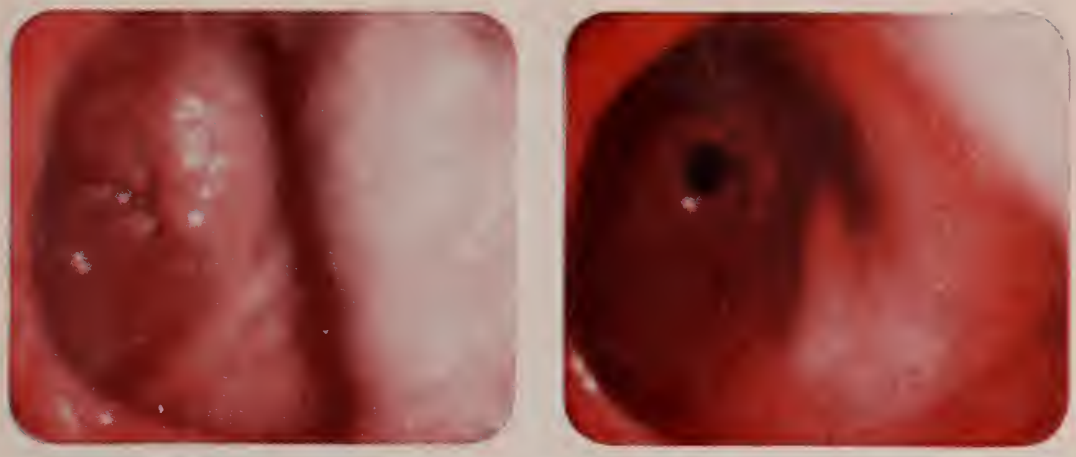
The clinical course of patients with coarsely nodular pulmonary fibrosis is determined by the extent of the involved lung tissue. With extensive involvement the illness may be fatal, but in general it tends to be clinically less severe than diffuse fibrosis.

Rheumatoid lung disease encompasses a wide range of pathologic alterations, varying from insignificant fibrous pleural adhesions to progressive and fatal diffuse fibrosis. The high frequency of lung disease in rheumatoid patients suggests that the rheumatoid process is essential or at least important to its cause. But the lack of correlation between the intensity of the arthritis and the severity of the lung disease suggests that the rheumatoid process alone is not responsible for the lung involvement.

The exceptional reactivity of the lung tissue in patients with rheumatoid disease makes it seem reasonable to propose that ordinary pathogenic stimuli, particularly viral and bacterial infections, may provoke an intense response and, ultimately, severe lung pathology in the rheumatoid patient.

New Jersey Tuberculosis and Health Association

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Intragastric photography studies[1]

A/ E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

B/ Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.

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1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

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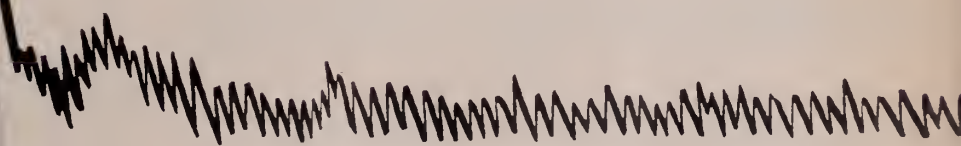
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It is now time to begin the initial work of the preparation of the 1966-67 **Membership Directory.** As a first step, within the next month or two each member will receive an informational data sheet. All members listed in the 1964-65 directory will be supplied with exact copies of their current directory listings and will be asked to verify or modify those listings, as the case may be. Members to be listed in the directory for the first time in 1966-67 will be asked to supply the full data requested.

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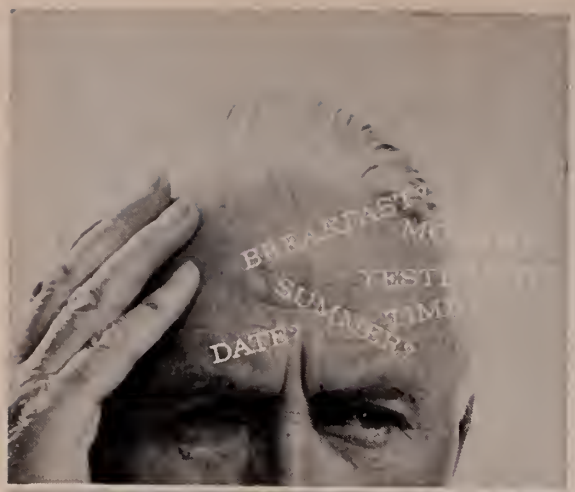
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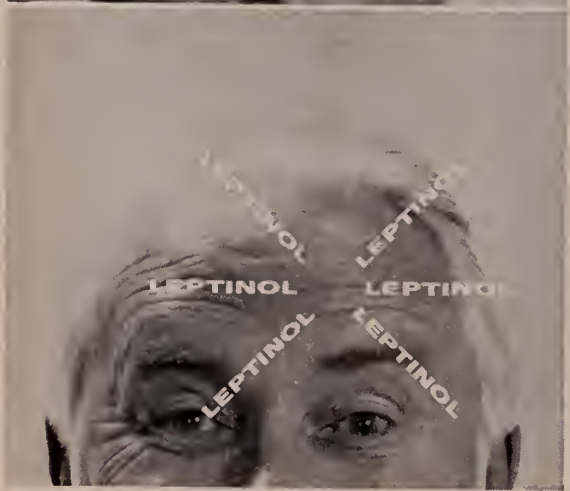
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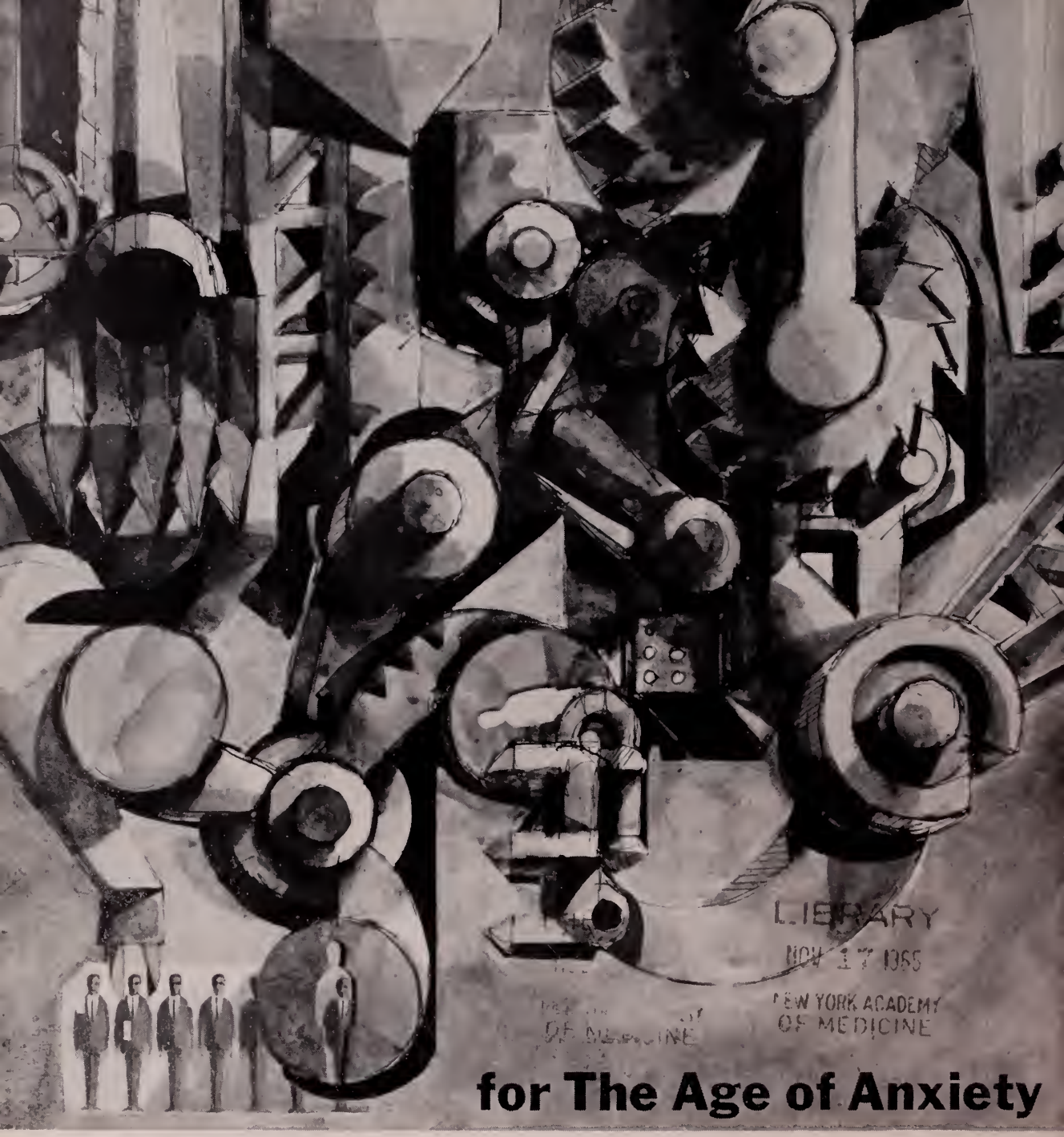
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December, 1965 Vol. 62, No. 12

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512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride. New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



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The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

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(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 19 (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. S Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. St Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P. Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. No. 12, Dec. 1963.

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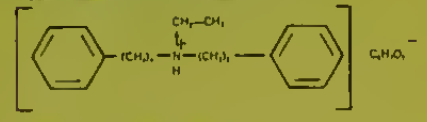
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*"The diagnosis is based upon a history of catharsis or enema habit, dietary indiscretion or emotional strain, generalized or lower abdominal distress of the type described, abnormality of the bowel movement and tenderness along the course of the colon." *Cecil and Loeb, A Textbook of Medicine, Tenth Edition*

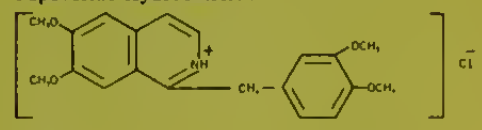


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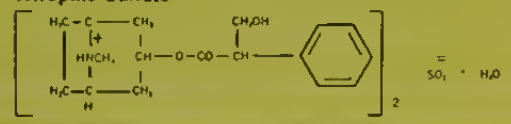
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- NOT an anticholinergic, therefore, has no atropine-like side effects.
- In man, its spasmolytic effect is two and one/half to three times stronger than papaverine with a longer duration of action.
- Neurotropic effect only 1/150 that of atropine.
- Has little or no effect on normal muscle tonicity and motility.
- Specific effect on the *sphincter of Oddi.*
- Mild local anesthetic effect and decreases gastric acidity.

---

the interesting results *in vitro* and *in vivo* with

NON-NARCOTIC **SPACOLIN™ 120 mg. tablets**

(Alverine citrate)

the potent musculotropic counter-spasmodic 2½-3 times stronger than papaverine

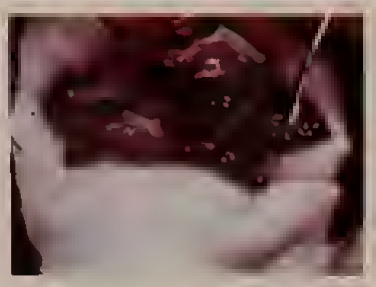
IN LABORATORY

Studies with isolated tissue have furnished investigators with important information as to the qualitative and the quantitative activity of certain therapeutic agents. This technique consists of recording the motility of a segment of rabbit ileum suspended in Tyrodes solution at a constant temperature of 37.5°C. The movements of this smooth muscle strip are recorded on a kymograph. The rabbit ileal muscle is remarkably sensitive to spasm-producing drugs. Once a spasm has been initiated, additions of a very small quantity of a musculotropic agent produces an immediate relief of the spasm or relaxation of the muscle. The study of SPACOLIN along these lines indicated the following:

1. SPACOLIN has little or no effect on normal smooth muscle tonicity. The addition of Spacolin to a normal ileum muscle strip does not change the muscle tonus or contraction.

2. SPACOLIN is a musculotropic counter-spasmodic having an activity more than twice that of papaverine.

3. SPACOLIN is a weak neurotropic spasmolytic agent with an activity of approximately 1/150 that of atropine sulfate.







IN MAN

Double-Blind Study of a Spasmolytic Compound[1]

By ITALO EVANGELISTA, M.D.

Assistant in Medicine, Tufts University School of Medicine, Boston, Massachusetts; Medical Staff, Cambridge City Hospital, Cambridge, Massachusetts; Malden Hospital, Malden, Massachusetts; Whidden Memorial Hospital, Everett, Massachusetts.

RESULTS*	ACTIVE MEDICATION		PLACEBO	
Excellent	9	80%	1	25%
Good	11		5	
Fair	3	20%	7	75%
Poor	2		12	
TOTAL	25		25	

*Excellent — complete relief of symptoms during therapy.
Good — definite relief but still aware of symptoms periodically.
Fair — symptoms reduced in intensity but still present.
Poor — little or no therapeutic benefit.

"... a definite conclusion could be drawn from the study, namely, alverine citrate (Spacolin), is an excellent aid in the management of spastic gastrointestinal disorders."

[1] To be published



THE GATE OF HELL. — RODIN

SPACOLIN™* IS HELPFUL

(Alverine citrate)

*A SPECIFIC MUSCULOTROPIC COUNTER-SPASMODIC





NON-NARCOTIC

For fast relief of spasm

PRODUCT INFORMATION

Each tablet contains: Alverine citrate (Bis-gamma-phenylpropylethylamine citrate) ..... 120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in **spastic colon**, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer†, cardiospasm, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations.

†Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, cardiospasm or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

SUPPLIED: Bottles of 100 and 500 — 120 mg. tablets.

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Because cerebrovascular insufficiency can be controlled

...help the older patient enjoy life with less confusion, defects in memory, dizziness, weakness, fatigue and decreased activity by maintaining the cerebral blood flow.

Administration and Dosage: Two sublingual tablets three times a day until definite improvement is achieved. This usually occurs within four weeks. Maintenance dosage of one sublingual tablet three times a day is then established to continue this improvement.
Precautions: Hydergine sublingual tablets have not been found to produce serious side effects even in doses far beyond the ones recommended. Some nasal stuffiness due to adrenergic blockade, transient nausea or gastric disturbances have been reported with high dosages.
Supplied: Hydergine Sublingual Tablets, 0.5 mg.; bottles of 100 and 1000.
Composition: Each sublingual tablet contains dihydroergocornine, dihydroergocristine, and dihydroergokryptine methanesulfonates (in equal parts), total 0.5 mg.

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12A

DEPROL®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.
Before prescribing, consult package circular.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-6405

FOR THE



COMPLEX

TRY DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

a logical first choice

FOR DEPRESSION

even when complicated by anxiety, tension, insomnia, agitation or rumination.

- **Acts rapidly.**
- **Side effects at recommended dosage infrequent, usually easily controlled.**

IMPORTANT FACTS

about

Professional Liability Coverage

Insurance that only covers claims based on the rendering of, or failure to render, professional services, or arising out of malpractice error or mistake in rendering professional services, is no longer adequate.

Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

(1) the non-negligent as well as the negligent claim, such as arising out of duties as committee member in your society or hospital.

(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

(3) punitive damages for libel or slander.

This program, which was designed with The Medical Society of New Jersey and its legal counsel, and operated by a cooperative Loss Control Program, offers this broad protection, security and continuity of coverage.

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be controlled by price.

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for the comprehensive control of the pain cycle

TRANCO-GESIC®

CHLORMEZANONE with ASPIRIN

100 mg. 300 mg.

Because pain is frequently aggravated and perpetuated by both anxiety and muscular tension, the combination of aspirin with a well tolerated tranquilizer—muscle relaxant (Trancopal® brand of chlormezanone)) is exceptionally effective.

TRANCOPAL is a "Tranquilaxant" which calms anxiety and tension, relieves muscle spasm, and enhances the analgesic effect of aspirin by subduing *emotional responses* to pain.

NON-NARCOTIC ANALGESIC, with tranquilizing and muscle relaxant properties

In low back pain

sciatica, lumbago; musculoskeletal pain associated with strains and sprains

In tension headache

premenstrual tension and dysmenorrhea

Side effects such as gastric distress, occasional weakness, sedation or dizziness may be noted. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. TRANCO-GESIC should not be administered to persons known or suspected to have an idiosyncrasy to acetylsalicylic acid.

Dosage for adults is usually 2 tablets three or four times daily, the suggested dosage for children from 5 to 12 years is 1 tablet three or four times daily.

Winthrop

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A big THANK YOU! From BLUE SHIELD

New procedures . . . additional forms to fill out . . . more paperwork . . . more headaches . . . these are some of the "necessary evils" that beset physicians and Plan alike when massive undertakings, such as implementing a new Subscription Certificate and a new Schedule of Payments, get under way.

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It's true a few physicians are still having trouble with the new forms for Special Consideration Consultation and Intensive Care, and in adjusting to some changes in time-honored procedures. We know that these things take time. By and large, though, the understanding and cooperation of the profession has been great . . . and we do apreciate it.

To show it's not a one-way street, we're working hard on some projects that we hope will make life easier for doctors . . . better claim forms . . . a new coverage code guide . . . and a few more ideas. Meanwhile, thanks again!

BLUE SHIELD®
MEDICAL-SURGICAL PLAN
OF NEW JERSEY
500 Broad Street, Newark

Butazolidin® alka

Each capsule contains:

Butazolidin, brand of phenylbutazone	100 mg.
dried aluminum, hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

in painful shoulder



Geigy

Therapeutic Effects
The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

Also available:
Butazolidin®
brand of phenylbutazone
Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

BU 4010P

First of all for mild hypertension



Serpasil® (reserpine)

Start with Serpasil (reserpine)
- produces a gradual, sustained lowering of blood pressure, especially in the neurogenic type of hypertension.
- relieves anxiety and tension, induces a sense of well-being in hypertensive patients with a low reaction threshold for stressful situations.
- slows the rapid heart and maintains the slowed rate.

Build on Serpasil (reserpine)
- serves as baseline therapy for certain other more potent antihypertensive agents.
- permits lower dosage of added potent antihypertensive drugs, minimizing incidence and severity of side effects.
- brings about increased therapeutic response when combined with certain other antihypertensives.

Serpasil®
(reserpine CIBA)

INDICATIONS: Mild to moderate hypertension. CAUTIONS: Severe mental depression has appeared in a small percentage of patients, primarily in a dosage above 1 mg daily. Usually the patient had a pre-existing, incipient, endogenous depression which was unmasked or accentuated by reserpine. When the drug is discontinued, depression usually disappears, but hospitalization and shock therapy are sometimes required. Daily dosage above 0.25 mg is contraindicated in patients with a history of mental depression or peptic ulcer; use lower doses with caution. Not recommended in aortic insufficiency. Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to reverse hypotension and/or bradycardia. Use cautiously with digitalis, quinidine, or guanethidine. When patients on reserpine receive electroshock therapy, use lower milliamperage and a shorter duration of stimulus initially. Shock therapy within 7 days after giving the drug is hazardous. SIDE EFFECTS: Occasional: lassitude, drowsiness, nasal congestion, looseness of stools, increased frequency of defecation. Rare: anorexia, headache, bizarre dreams, nausea, dizziness. Nasal congestion and increased tracheobronchial secretions may occur in newborn babies of mothers treated with reserpine. AVERAGE DOSAGE: *Initial*—Two 0.25-mg tablets p.c. daily. *Maintenance*—Reduce daily dosage to 0.25 mg or less p.c. SUPPLIED: *Tablets,* 0.25 mg (white, scored) and 0.1 mg (white).
CIBA Pharmaceutical Company
Summit, New Jersey

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not all your patients
are overweight**



**but
for those who are...**

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d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.)

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Sustained Release Capsules

Most overweight patients could benefit from the appetite control provided by the prolonged anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action through the central stimulant effect of the amphetamine; tranquilizing action with only mild sedation through meprobamate; prolonged action through sustained release of active ingredients.

Contraindications: Hyperexcitable and prepsychotic states; patients hypersensitive to meprobamate.

Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

Lederle

6208

Anatomy of
Low Back Pain #1



the sedentary life is often the seat of low back pain

The human spine is not engineered
prolonged sitting at desks, pianos, ty
writers and drafting boards. The stres
set up by the heavy, forward-tilted h
and trunk, balanced precariously on
insufficient base, result in strain of
dorsal musculature, particularly at
low lumbar level.

The unusual muscle-relaxant and a
gesic properties of 'Soma' make it es
cially useful in the treatment of low b
sprains and strains. 'Soma' is wic
prescribed ☐ **to relieve pain** ☐ **to re**
muscles ☐ **to restore mobility.**

Indications: 'Soma' is useful for managemer
muscle spasm, pain, and stiffness in a variet
inflammatory, traumatic, and degenerative mu
loskeletal conditions. It also may act to norma
motor activity in certain neurologic disturban

Contraindications: Allergic or idiosyncratic r
tions to carisoprodol.

Precautions: 'Soma', like other central nerv
system depressants, should be used with cau
in patients with known propensity for taking
cessive quantities of drugs and in patients
known sensitivity to compounds of similar che
cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with
frequency is sleepiness, usually on higher t
recommended doses. An occasional patient
not tolerate carisoprodol because of an indivic
reaction, such as a sensation of weakness. Ot
rarely observed reactions have included dizzin
ataxia, tremor, agitation, irritability, headache,
crease in eosinophil count, flushing of face,
gastrointestinal symptoms.

One instance each of pancytopenia and le
penia, occurring when carisoprodol was adr
istered with other drugs, has been reported, as
an instance of fixed drug eruption with carisopro
and subsequent cross reaction to meprobam
Rare allergic reactions, usually mild, have inclu
one case each of anaphylactoid reaction with r
shock and angioneurotic edema with respira
difficulty, both reversed with appropriate thera
In cases of allergic or hypersensitivity reactic
carisoprodol should be discontinued and appro
ate therapy initiated. Suicidal attempts may
duce coma and/or mild shock and respirat
depression.

Dosage: Usual adult dose is one 350 mg. tal
three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tab
and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strain

SOMA
(CARISOPRODOL

Wallace Laboratories, Cranbury, N.
2650



Low host resistance?

Consider the "extra" antibacterial activity of Ilosone®

Occasionally, therapeutic failure is due to the patient's inability to mobilize his defenses sufficiently to overcome infection. Typical of this is the debilitated patient, the premature infant, or the diabetic. It is in these patients that the high levels of antimicrobial activity of Ilosone are especially useful. Ilosone has demonstrated antibacterial levels two to four times those of erythromycin base or stearate. Furthermore, it attains them earlier and maintains them longer. Even the presence of food does not appear to affect the activity of Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Dosage: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules®, suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

Ilosone®

Erythromycin Estolate

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana. 501280

Lilly

EDITORIALS

William G. Herrman 1890-1965

One of the most active medical and civic lives in our State came to a close on November 7 with the death that day of William G. Herrman, M.A., M.D. He was the President of The Medical Society of New Jersey 1937-8, taking the helm in a year when the great depression had fastened itself on the country; when new experiments in medical economics, group practice, and health insurance were in the air; and when organized medicine needed strong leadership. And William Herrman supplied it.

He earned a baccalaureate degree at Rutgers in 1912, and his M.D. in 1916 at the New York Medical College. Completing an internship at New York's Metropolitan Hospital, he returned to his home state. After a brief period of general practice he did graduate work in radiology and roentgenology in Chicago and Philadelphia, and became one of the earliest practitioners of that specialty in New Jersey. His commanding qualities must have been apparent early. He joined the Monmouth County Medical Society in 1919; by 1925 was president of that organization. He became active in State Society activities, and wthin another decade was vice president of The Medical Society of New Jersey—becoming its President in 1937.

Dr. Herrman came from truly pioneer American stock. He was a lineal descendent of Peregrine White, the first Anglo-Saxon child to be born in America. He was also a direct descendant of Andrew Jackson, seventh President of the United States.

He did not confine his activities to organized medicine. He was president of the Board of the Asbury Park Presbyterian Church and of the Rotary Club. He was active in the Sons of the American Revolution and in the American Legion. He was a tax assessor in Deal, a Jury Commissioner for Momouth County, and State Chairman of the Advisory Committee to Selective Service. He headed the State Radiologic Society in 1934. In 1938 he was awarded the coveted Rutgers Medal for Service to Health and Medicine.

New Jersey radiology owes much to William Herrman. More than any man, he actually establishd or developed x-ray departments at Fitkin, Monmouth Memorial, and Middlesex General Hospitals. He was a director of the Allenhurst National Bank and on the board of governors of the Monmouth Medical Center. Dr. Herrman made numerous contributions to medical literature. As far back as 1922, he published an article on melanotic carcinoma in this JOURNAL. He did original work in the radiologic interpretation of lung diseases.

He was a lively participant in board and committee meetings at the State Society level. He made his position on all issues clear and unequivocal. In the 1930's and 1940's, he supplied firm creativity and direction. In the 1950's he was a source of sage support and sound advice on medical and administrative problems in our organizational work. He lived a long, useful, and interesting life; and his passing leaves a genuine gap in the leadership of organized medicine in New Jersey.

Debauching The Innocent

Physicians, as citizens, are concerned with the physical and emotional well-being of people —especially young people. And this cannot be separated from the "moral" health of people, either. Certainly the family doctor, the pediatrician, and the psychiatrist have a direct concern about the pollution of minds, just as the internist and the phthisiologist have about the pollution of the air we breathe.

There is now pending in our State Senate a bill (A-768), already passed unanimously by the Assembly, which defines the word "obscene" and bans the distribution to children under 18 of obscene material. This bill essentially re-defines an adjective already in the statute. Thus, it seems to be an exercise in legal semantics, apparently beyond the area of interest of doctors, as a professional group. However, doctors as individual citizens (and, we like to think, influential ones) do have a concern here.

Let it be noted that this does not censor serious works of art or health education. It applies only to peddling pornography to children. And, by spelling out in some detail what the adjective "obscene" means, the proposal avoids the problem of "vagueness" which has ham-strung previous efforts to put a stop to the debauchery of susceptible individuals.

Modern criteria of obscenity began with the several nineteenth century definitions. (In law, that's modern.) The formulas, both in the USA and Great Britain, used such tests as "depraving the morals of the reader" or "debauching his mind," or "writing that would suggest to the mind thoughts of an impure and libidinous character." Generally considered as the landmark case, Regina v. Hicklin (England 1868) laid down the criterion: "whether the tendency of the matter is to deprave and corrupt the minds of readers which might be open to such immoral influence."

Until 1913, American law generally took the position that if *any part* of a published work might debauch even the *most vulnerable* reader, the work was obscene. However, in 1913 Judge Learned Hand[1] said that ". . . the rule laid down in the Hicklin case does not answer to the morality of the present. I doubt if men will, in the end, regard as obscene that which is honestly relevant to the adequate expression of innocent ideas. We need not reduce our treatment of sex to the standard of a child's library in the interests of a salacious few. Society need not accept for its own limitations those which may be necessary for the weakest of its members."

The "most susceptible person" formula—condemned here by Judge Learned Hand—was again rejected in the federal courts[2] which held that "a book must be tested as to its effect on a person with average sex instincts; and must be judged as a whole and not by isolated passages ripped out of context."

Two shields were thus made available to some of the pornography pushers. One was to argue that sophisticated readers would not be debauched by their works and that the law need not concern itself with the effect on more innocent readers. The other was that an obscene paragraph or two were tolerable, if they were outweighed by non-erotic material. This led to a concept that obscenity could be fully protected by an appeal to freedom of speech. At this point, our fellow-Jerseyite, Associate Justice Brennan, speaking for the majority of the U. S. Supreme Court, put it this way: "Obscenity is not within the area of constitutionally protected speech or press. Obscene material is material which deals with sex in a manner appealing to prurient interests, having a tendency to excite lustful thoughts. The test is whether, *to the average person,* applying contemporary community standards, the dominant theme of the material *as a whole* appeals to prurient interests."[3]

In this day, most American and British courts seem to say that material which stimulates sexual thoughts is not *ipso facto* obscene. It is the tendency to deprave, debauch, and corrupt that gives the material its "obscene" character. The concept of pornography (as distinct from obscenity) is an interesting one. Webster doesn't help us much, since the word is Greek for "writing about harlots." Dr. Margaret Mead, however, does help. She suggests that "pornography is material calculated to stimulate sex feelings independent of the presence of the other loved and chosen human

1. In USA v. Daniel Carson Goodman
2. In USA v. James Joyce's Ulysses, in 1934
3. In USA v. Roth, cited on page 56 of "To Deprave and Corrupt." Edited by John Chandos. Toronto, Canada, 1962. Ryerson Press

beings. The essence of pornography is that it encourages day dreams rather than reality. Pornography bears the signature of nonparticipation: of the dreaming adolescent, the impotent, the frightened, the bored, the sated, and the senile."[5]

Kronhausen[4] points out that the typically pornographic work is made up of a succession of erotic scenes, with hardly any nonerotic passages: that the work does not describe or deal with the basic realities of life, since its sole purpose is to stimulate erotic response. The adjective *hard core* is often applied to works which, in a form that normal people find rather shocking, aim at nourishing the erotic fantasies of sexually immature persons. It is no coincidence that the prime patrons of strip tease are lonely old men, day-dreaming middle-aged ones, or frightened adolescents.

New York's ex-mayor Jimmy Walker was once quoted[6] (objecting to censorship) as saying that no girl was ever ruined by reading a book. Mr. Walker was not a good psychiatrist. Most people—and nearly all adolescents—are dealing constantly with streams of fantasies—conscious, subsconscious, unconscious. Some books and magazines are deliberately aimed at generating new fantasies or diverting old ones into socially undesirable directions for the profit of the publisher or distributor.

In supporting more enforceable obscenity laws, the New York Academy of Medicine cites the substantial and recent increases in illegitimate maternity and adolescent venereal disease, and suggests that this is related to the spread of repulsive and cut-price pornography. The Academy also reminds us that if doctors shirk their traditional responsibilities in sex education, another—and unsafe—kind of sex education is readily and cheaply available through lurid paper backs and magazines beamed at the more drooling of the teen-age audiences.

There is no shortage of laws on the subject, but enforcement has been complicated by the vagueness of previous definitions and a reluctance to appear as censors interfering with free speech and free press. These are the objections which A-768 seeks to meet.

New York Medicine,[7] speaking for its county medical society, urged doctors "as citizens and protectors of children to work for legislation prohibiting the distribution of pornographic literature to young people."

As a medical society, we take no position on a restatement of a statute. However, as the traditional protector of the young and of the family—as citizens—we can scarcely be indifferent to this problem in an already turbulent society.

Dispensing The Sample

The samples you get from drug companies are intended for one purpose: to be given to patients as a trial. However, if no written prescription accompanies the sample, the transaction looks like the dispensing of a home remedy; or looks as if the patient is being used as a guinea pig. Common sense suggests that the sample should be accompanied by a written prescription for the same item.

It might be best to tell the patient: "This is a sample of a new (or a good old) medicine that has had some fine results. If it is as favorable as I expect it to be, take the prescription to your neighborhood drug store so you can get more of this medicine. If you are disappointed in the results, call me."

This simple procedure will prevent the embarrassment of an otherwise satisfied patient trying to get the drug without a prescription. It will lift the medication into the dignified "prescription" class rather than make it look like a casual free sample. It indicates that the doctor is not going out on a limb, calling it a wonder drug. And it acts as an automatic (if not entirely scientific) check on the effectiveness and safety of a new drug.

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4. Kronhausen, E.: New York, 1959, Ballantine Books—"Pornography and the Law"
5. Page 67 of "To Deprave and Corrupt": Citation 3 above
6. *Time* magazine, April 16, 1965
7. Page 201 of the issue of April 5, 1965

ORIGINAL ARTICLES

Have you ever seen one of these 200-bed packaged emergency hospitals? Better look now. Some day you might be needed to work in one. If the doctors won't, others will.

Disaster Packaged Hospital

Annex to Established Hospital

Jack R. Karel, M.D.*/Hillside

The first 200-bed Civil Defense Emergency Hospital (DPH) appeared in this country in 1956. It was developed by the United States Public Health Service. Since then over 2,000 of these units have been prepositioned in strategic areas all over the nation. These hospitals are completely equipped general medical and surgical units. All CDEH† units that have been released and prepositioned since 1962 are capable of operation for thirty days. Expansion units to increase the capability of the earlier model are also available and being prepositioned.

These "packaged hospitals" are mobile units that can be transported by two 40-ton trailer trucks to places where the hospital would be activated. The designated sites are usually schools or other buildings having a large auditorium. These CDEH's† are packed in boxes and designed to provide austere but adequate medical care to the disaster victims.

The supplies and equipment can be used to expand the capability of existing community hospitals; or to establish a completely independent hospital with the following sections: admitting and triage (sorting); wards; operating rooms; x-ray unit; laboratory; pharmacy and central supply which includes preparation, sterilization, and stores subsections. There are generators for auxiliary power, should the local electrical supply be disrupted. A 1,500 gallon water tank with a pumping unit is included for emergency water supply. Even medical and administrative record forms are furnished.

Newer concepts have evolved in the use of the 200-bed CDEH.† In addition to its availability near a large area of disaster, this hospital may be used to replace a fixed hospital. It may also be used for the establishment of first aid posts in communities.

Now that we have all these hospitals what shall we do with them? They represent an investment of millions of dollars of taxpayers money — your taxes. Shall we let them go down the drain for lack of someone responsible — like you — to operate them? No more than five per cent of all physicians have ever seen one of these units. Yet, they have been shown all over New Jersey. How many are properly staffed with professional personnel so that they may be used in a major medical emergency? Very few. What is required to motivate the physician for a responsibility that is logically his? This is the problem we face in the utilization of the 200-bed Civil Defense Emergency Hospital.

Staffing with medical and paramedical per-

* This is written by Dr. Karel in his capacity of chairman of the Committee on Disaster Medical Care of The Medical Society of New Jersey.

† The abbreviation CDEH means Civil Defense Emergency Hospital.

sonnel appears to be the major issue. It thus seems reasonable that all these units should be utilized as annex hospitals to the already established hospitals of the community. Each CDEH† could be sponsored by the fixed hospitals for emergency staffing and operation and with no monetary responsibility involved.

In arranging for professional and paramedical staffing, *the established hospital disaster plan must not be disturbed.* However, other members of the active staff would be assigned to the CDEH†. In a major medical emergency calling for the activation of the disaster hospital, skeletonizing the fixed hospital should not be a problem. It should be noted that *only ten physicians are required for each civil defense emergency hospital.*

To staff the emergency hospital, there must be close liaison with the county civil defense coordinator and his medical coordinator. Through these officials, additional manpower will be obtained. Others who could be utilized in the staffing pattern are dentists, veterinarians, podiatrists, pharmacists, laboratory technicians (from private laboratories), and private radiologists and their technicians. Nurses' aids could be assigned from the community hospital. Additional personnel may be obtained from the Medical Assistants' Society whose members work in doctors' offices; administrative personnel are also needed. Additional nurses and aids could be recruited from the the general public. Maintenance personnel from the hospital would be utilized in setting up the CDEH.†

Once the professional and paramedical staffing was completed, the training phase would start. Training aids are already available in the fixed hospital. Others would be obtained from the State Department of Health. This includes a compact manageable training unit containing 20 cots to acquaint personnel with the contents of the CDEH† and its assembly.

In World War II, many institutions sponsored complete hospital units as large as thousand bed general hospitals. Surely we can do it again — and much more easily this time, for the CDEH† is not too large. Both training and operating equipment are already available.

The time may shortly be upon us when serious decisions will have to be made as to the health resources of the state and nation. Will the medical profession have the knowledge to make such decisions? By executive order, the policy of the Federal government on the use of health resources in a major emergency period provides that: "All decisions regarding the use of resources will be directed to the objectives of National Survival and Recovery."

115 North Avenue

High School Smoking and Example-Setting

Efforts to foster discontinuance of cigarette smoking (and to prevent it) have been largely focused on young people. It is questionable, however, to believe that even this limited goal can be achieved if the older age-group does not change its own habits. " . . . we must recognize that many adults serve as exemplars to youth. Parents, physicians, dentists, others in the health professions, ministers, athletes, and . . . the teacher."*

For this reason, it would be desirable to convene meetings to discuss the teacher's role as example-setter—not to coerce, but simply to evaluate and recognize "the degree to which (the teacher's) smoking behavior affects his own attitude and the effectiveness of his teaching about the effects of smoking." The establishment of a non-smoking milieu is of the utmost importance: a milieu in which smoking is no longer an acceptable form of behavior taken thoroughly for granted.

* *Cigarette Smoking in the High Schools.* Horn, D. Chief, Special Projects Section, Cancer Control Program, U.S.P.H.S. Presented at the meeting of the American Association of School Administrators, Atlantic City, N.J., February 17, 1965.

Conservative surgery is helpful in a high proportion of patients with Meniere's Disease.

Meniere's Disease and Its Surgical Treatment*

David F. Austin, M.D./Chicago, Illinois

Therapy in Meniere's Disease is confused because of the many and varied drugs and regimes which have been proposed. The nature of the disease itself is responsible for this, since it is a frustrating experience for the physician to be unable completely to control the debilitating symptoms of vertigo while waiting for the hearing to deteriorate to a level that will permit the consideration of vestibular destruction. Since the basic etiology of this disease is unknown, medical treatment has been empiric with consequent disappointment in obtaining reliable or long term control. Until the basic cause of Meniere's Disease is discovered, the primary aim of therapy must be the control of the endolymphatic hydrops which leads to the vertigo and characteristic cochlear deterioration. This thesis is similar to the therapeutic problem of essential hypertension where treatment is directed to lowering arterial pressure to prevent the complications of that disease.

From metabolic studies it is clear that there is a rapid production of endolymph. This most likely occurs at the stria vascularis, since it is the only structure with the inner ear capable of this function. The site of reabsorption is less clear. Some think that this occurs in the endolymphatic sac; others, that the stria are responsible for this function also. Little is known concerning the control of this mechanism. We do not know whether a defect exists in the productive or absorptive processes or both in Meniere's Disease. Until these facts are determined, the most rational form of treatment is to allow relief from the excess fluid present in the endolymphatic system in such a way as to avoid damage to the membranous labyrinth.

Conservative surgery in Meniere's Disease was pioneered by Dandy,[1] who proposed intercranial partial eighth nerve section. This treatment was effective in controlling vertigo; but since it did not influence the endolymph, progressive fluctuating deterioration of cochlear function generally took place.

The first attempt to achieve our expressed goal in treatment was made by George Portmann[2] in 1926. Although he lacked objective evidence of endolymphatic hydrops, he postulated this as the cause of the symptoms. He then developed a surgical approach to the endolymphatic sac which he incised to achieve decompression. This was fraught with technical difficulties, as the power driven burr and operating microscope were not yet available to assist in this delicate dissection. Flett[3] reported that, in 73 such procedures, two post-operative deaths occurred. It is probable that such difficulties were largely responsible for the lack of widespread acceptance of the operation, since the same report[3] indicated perfect results in 19 and control of vertigo in 23 others.

Other efforts toward our therapeutic goal were by Passe[4] and Seymour. They tried to control endolymphatic production through

* Read May 17, 1965 at Atlantic City before the Otolaryngology Section of The Medical Society of New Jersey. Dr. Austin is chief of the Otology Section at University of Illinois College of Medicine.

cervical sympathectomy. The efficiency of this method was not proved. There were many good though inconsistant results. Meurman[5] tried to decompress the inner ear by lateral semicircular canal fenestration. While this did control vertigo, it resulted in a high frequency of hearing loss.

Plester and later Fick[6] attempted to drain the endolymphatic system by attacking the saccule through the stapes footplate. It was postulated that a fistula was created which remained patent and thus controlled symptoms. Although Fick[6] reported good results in improved hearing, other's experience, including my own, indicated that hearing is lost in most cases although vertiginous symptoms do seem to be well controlled.

The most significant advance in conservative surgery occurred when House[7] modified the original Portmann procedure[2] and reported a series of cases in 1962. He showed that, by application of current otosurgical technics utilizing the operating microscrope, the procedure was a relatively simple exercise and that modern postoperative management of these cases prevents the occurrence of complications. Experience over the past 3 years[8] has verified, to date, the initial successes which were reported.[9] A recent paper by Portmann[10] has now reported their accumulated experience since 1926 and has shown the consistancy of results over this period of time.

The technic of the procedure is to do a simple mastoidectomy, removing the mastoid cells lateral to the labyrinthine block. The lateral sinus is skeletized and the bone of the posterial dural plate thinned until the region of the posterior semicircular canal is reached. Usually the endolymphatic sac can be seen through the thin bone which is then removed from its mastoid aspect. The duct usually emerges from the temporal bone in the region of the midpoint of the curve of the posterior semicircular canal and the sac fans out between this structure and the lateral sinus. Care must be taken to avoid injury to the posterior canal as hearing loss usually accompanies this accident (Figure 1).



FIGURE 1

The endolymphatic sac is then opened and a small Teflon® drain inserted through the posterior wall of the sac into the subarachnoid space (Figures 2 & 3). We have recently



FIGURE 2

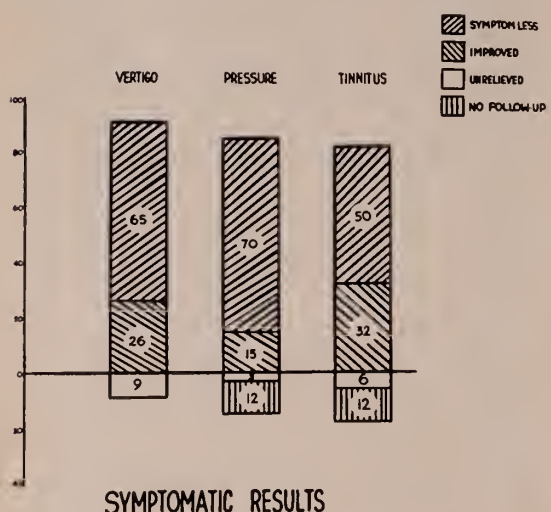
eliminated the use of plastic. A portion of the posterior wall of the sac is now excised in an effort to achieve a fistula which will remain patent permanently. Considerable time will have to pass to see if this variation will be



FIGURE 3

successful in correcting the chief difficulty of the procedure which has been plugging of the plastic drain by arachnoid.

Over seventy of these procedures have been done by the author to date. Observations have been made on 32 of these patients over periods of from 18 to 30 months. Success has been judged by measurement of hearing and discrimination improvement as well as by elimination of the symptoms of vertigo, tinnitus, and intra-aural pressure. Vertigo was eliminated in 65 percent and markedly improved in 26 percent of patients. Tinnitus was less easily corrected with only 50 percent experiencing relief (Graph 1). That this procedure was effective in allowing hearing to improve was shown by the marked gain in bone conduction (20dB or greater) in 19 percent and in speech discrimination (20 percent or more) in 20 percent of the patients (Graphs 2 & 3).



SYMPTOMATIC RESULTS

GRAPH 1



CHANGE IN BONE CONDUCTION RESPONSE AFTER SHUNT

GRAPH 2

The most troublesome aspect of the procedure has been the plugging of the Teflon® drain by extension of arachnoid into its lumen. This occurred in 10 percent of the patients, causing recurrence of symptoms after an initial period of relief. To prevent this, a new type of drain was designed which was shaped into a grommet. This has also proved to be subject to the same difficulty. For these reasons, it now is the practice to excise the posterior wall of the sac hoping to allow free drainage of endolymph into the subarachnoid space. This has given good initial results; and because of the experience of Portmann with a basically similar method, it is felt this should continue to be successful.



CHANGE IN SPEECH DISCRIMINATION AFTER SHUNT

GRAPH 3

This operation does not cure Meniere's Disease nor does it control the symptoms in

every case. However, it is indicated in any patient with remaining useful hearing prior to destructive labyrinthectomy. The possibility of a unilateral involvement becoming bilateral in any individual case dictates the necessity of conservatism and the need to preserve or improve any remaining cochlear function. For this reason (and because of the better results in early Meniere's Disease), serial audiometry should be done in every case and the endolymphatic shunt operation seriously considered when these tests show progressive hearing impairment.

Summary

1. The development of conservative surgery for Meniere's Disease has been reviewed. Conservative treatment in essence must control the production of endolymph or allow for the escape of excess fluid for this form of treatment to be effective.

2. The technic of the endolymphatic shunt operation was described and the results of its use in 32 patients followed for at least 18 months after surgery was charted. The operation was effective in controlling symptoms in the majority of these patients and 20 percent showed a marked hearing gain. Indications for this procedure were outlined.

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Task Force Report on Tuberculosis Control

The American College of Chest Physicians and the American Thoracic Society in the March 1965 issues of the *Diseases of the Chest* and the *American Review of Respiratory Diseases* publish a joint statement wholeheartedly endorsing the recommendations on tuberculosis control of the Task Force of the U. S. Public Health Service.

The statement urges that the recommendations of the Task Force Report be meticulously studied and that the control measures applicable in various communities be vigorously applied. It states that: "The medical profession is in an important position to endorse this report and to encourage local, state, and national political leaders to take the action necessary to provide additional funds for this work." Included is a summary of the main provisions of the Task Force Report on Tuberculosis Control and major considerations in evaluating a community's tuberculosis control efforts. It stresses that "The accomplishment of these objectives can best be attained when responsible leaders in public health agencies, medical organizations, voluntary tuberculosis associations, and public office work together to mobilize the community skills and resources to accomplish the task."

The full Task force Report on Tuberculosis Control is available from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 at 25¢ a copy.

Corneal changes may signal systemic disease, and the careful practitioner does not limit himself to purely intra-ocular conditions when he searches for the cause.

Corneal Manifestations Of Systemic Diseases*

Alfonse Cinotti, M.D./Jersey City

The extent to which systemic diseases contribute to corneal conditions is not significant. Some infectious diseases—such as syphilis, measles, herpes zoster, and leprosy—are known to affect the cornea. Metabolic deficiencies—such as protein and fat disorders, as well as certain toxic substances such as chlorquine—have been implicated in corneal changes. These systemic degenerations must be differentiated from hereditary disorders which also cause corneal changes.

Distinguish between degeneration and dystrophies. *Degenerative* conditions result from environmental actions without hereditary or genetic abnormalities. Degenerations represent chemical and histological changes observed in a local inflammatory disturbance accompanying a known systemic disorder, as a manifestation of the aging process.[1] Examples are keratomalacia (vitamin A deficiency), pterygium (exposure to elements), band keratopathy (iridocyclitis, other intraocular disease), and lipid keratopathy (vascularized cornea in patients with elevated cholesterol).

A *dystrophy* is an hereditary alteration in the genetic constituents which alters the normal growth and developmental processes. This term is usually reserved for conditions which do not become manifest at birth.

Congenital malformations usually are genetically determined and present at birth but the abnormalities may be secondary, resulting from intrauterine infection observed in such degenerations as syphilitic interstitial keratitis. Occasionally overlapping may be present, as in arcus senilis. This is a physiologic phenomenon of senescence and consequently a degeneration; but it may also be found as a family characteristic in some patients.

Corneal Ulcers

Most corneal ulcers are primarily local diseases. Some, however, may be associated with conditions in other parts of the body. A common and sometimes difficult type of ulcer to diagnose and treat is the "superficial punctate" variety. Jones[2] has divided these ulcers into five groups:

1. Fine punctate erosion, usually caused by a virus.

2. Coarse punctate erosion. This usually has a virus etiology, but it may be caused by acne rosacea.

3. Subepithelial punctate keratitis, occasionally seen with acne rosacea, herpes zoster, keratitis or sicca. In most cases, this is due to adeno virus.

4. Filamentary keratitis where the epithelium has desquamated and remains attached at one end. This is most commonly seen in kerato-conjunctivitis sicca (Sjogrens disease), but it may be found with erythemia multiforme, psoriasis, and some viruses.

5. Deeper opacifications are observed in herpes zoster, vaccinia, and leprosy.

Punctate keratitis may be associated with the following groups of diseases:

1. Changes in facies, as seen in acne rosacea and Sjogrens disease.

2. Skin diseases, such as benign mucosol pemphigoid, erythema multiforme, leprosy, psoriasis, follicular hyperkeratosis of palms and soles, and icthyosis.

3. Respiratory diseases, such as adeno virus infections, myxo-virus infections, influenza, Newcastles disease, and

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mumps; and also as a recurrent herpes simplex complicating a fever.
4. Articular diseases, such as Sjogrens syndrome, psoriasis arthropathica, and Reiters disease.
5. Genito-urinary diseases, as inclusion blenorrhea, Reiters disease, erythema multiforme, benign mucosal pemphigoid, and the Stevens-Johnson syndrome.
6. Alimentary diseases, such as ulcerative colitis, which is probably a manifestation of the autoimmune process which may be responsible for this condition.[3]

A second type of corneal ulcer may be associated with systemic conditions which occur marginally. It appears as whitish grey lesions separted from the limbus by a clear narrow zone. These "marginal ulcers" are generally considered to be allergic responses, especially to staphylococcus toxin. However, it is more commonly found in older patients who are essentially nutritionally distressed. I saw a patient who had an anemic tendency, and each time her hemoglobin dropped below 10 Grams an ulcer of this type would develop. These ulcers have been seen in ulcerative colitis, periarteritis nodosa, and rosacea keratitis.

The typical hypopyon ulcer is generally due to pneumococcus or streptococcus infections of the eye. Most of these on our service at the Jersey City Medical Center were found in chronic alcoholics who were nutritionally distressed. In this sense, they may be considered a systemic disease. Many of these cases respond to massive vitamin and protein therapy in addition to antibiotics and steroid drugs.

Rosacea keratitis manifests a recurrent centripetal ulceration with occasional profuse neovascularization, which responds well to steroids in the early stages. Beta radiation may be necessary in later stages.[4]

Neuroparalytic keratitis is usually attributed to injury to the Gasserian ganglion or to herpes zoster. The patient may demonstrate punctate keratitis, dendritic keratitis, or a large disciform ulceration. A tarsorrhaphy is effective in protecting the cornea and relieving the condition.

Vaccinia ulcers are usually an accidental complication of vaccination. The prevention of secondary infection is the only treatment indicated.

Sjogrens syndrome is often first suspected in keratoconjunctivitis. Symptoms fall into three groups.[5] The *first* consists of manifestations of exocrine gland disorders. These include kerato-conjunctivitis sicca, xeromastia, enlarged salivary and lacrimal glands, dental caries, pharyngolaryngo-rhinitis sicca, tracheobronchitis, vaginitis, and achlorhydria. The *second* group are manifestations from other organs, including rheumatoid arthritis, splenomegaly, hepatomegaly, Raynaud's phenomenon, arteritis, focal myositis, neuropathy, alopecia, purpura, eosinophilia, leukopenia, and thrombocytopenia. The *third* group comprises protein abnormalities, such as hyperglobulinemia, positive rheumatoid factors, tissue antibodies, and thyroglobulin antibodies. In the early stages of Sjogrens syndrome, the diagnosis of corneal involvement may be made with a filter paper test, staining with rose benegal and the biomicroscopic observation of small areas of corneal drying. The latter may be the earliest sign of this condition.

Interstitial keratitis may be an ocular sign of congenital syphilis. It is usually accompanied by a positive serology and often by saddle nose, notched teeth, and deafness. The keratitis starts with a ciliary congestion followed by a hazy cornea which occasionally becomes vascularized, giving the typical appearance of a "salmon patch." Histologically, the middle and deep layers of the stroma become infiltrated with lymphocytes followed by the invasion of vessels and a necrosis of the corneal elements. The incidence of congenital syphilis has decreased almost to extinction because of the early diagnosis and treatment of syphilis during pregnancy. Other causes of interstitial keratitis include tuberculosis, herpes zoster simplex, leprosy, and trypanosomiasis.

The Metabolic Processes

The metabolic processes responsible for the maintenance of corneal transparency are not well understood. However, some corneal changes may be studied biomicroscopically to aid in the identification of a primary systemic disorder. Most of these changes have been as-

sociated with disordered fat or protein metabolism and in conditions of disturbed calcium or copper metabolism.

Arcus senilis (enbrytoxin) is the most common degeneration of the cornea. This begins as a deposition of fatty globules in Bowman's membrane and the overlying epithelium. The globules gradually extend deeper, but a clear corneal zone is left between it and the limbus. Investigators have been unable to demonstrate a constant elevation of the blood cholesterol, neutral fats, or phospholipids. Arcus juvenilis (which occurs under the age of 40) has been associated with familial hypercholesteremia, a high incidence of atheromatous vascular disease, and xanthelesamas of the eyelids. Vision is not materially imparied by arcus juvenilis.

In rare instances, deposition of fatty crystals in the deep and superficial layers of the corneal stroma have been observed, along with a hyperlipemia and hypercholeremia. Hereditary crystaline corneal degeneration (believed to be a deposition of cholesterol crystals in the superficial stroma) has been ascribed to a familiar disorder of lipoid metabolism.

Gargoylism is a generalized dysostosis known as lipochondro-dystrophy. It shows a characteristic corneal opacification. This begins soon after birth as small, whitish-grey spots in the anterior and central portion of the corneal stroma. These opacities become more dense until the entire cornea becomes grey. In this congenital and familial condition, the characteristic appearance is found in the kyphotic dwarf with coarse features, pronounced hepatosplenomegaly, and mental retardation. An abnormal substance (stored in the various tissues of the body) is believed to be a form of lipoid combined with mucopolysaccharide.

Keratomalacia has been associated with malnutrition, usually a deficiency of vitamin A. It is found in children with fever and diarrhea. The occasional lack of response to the systemic administration of vitamin A has led to the supposition that a deficiency of protein may also be involved.[5] In this condition, the cornea loses its lustre and develops whitish particles which coalesce. Pigmentation may occur with thickening of the cornea. Frequently, hypopyon ulceration develops followed by perforation.

Cases have been reported where either fine iridescent crystals or amorphous deposits were seen in the corneal stroma associated with dysproteinemia. This latter term includes cases of macroglobinemia, myelometosis and Bence-Jones protein in the urine.

A specific disorder of protein metabolism, where the essential amino-acid-methionine is broken to cysteine and accumulates in the tissues, is known as "Fanconi Syndrome." General features of this condition are renal rickets, glomerular and interstitial nephritis, dwarfism, and terminal uremia. There is an accumulation of multiple minute crystals throughout the corneal stroma without signs of inflamation, but associated with photophobia.

Porphynoria, a condition of excessive amounts of porphyrins in the urine, may also affect the cornea with dense nebulae, marked photophobia, and blindness. These patients are extremely sensitive to ultra-violet light.

Band-shaped keratitis is a common sequelae of degenerative diseases of the eye. Depositions of calcium in the cornea have also been seen in disorders of calcium metabolism. Cogan and Heneman[6] demonstrated its association with hypercalcemia due to hyperparathyroidism. In addition, vitamin D, intoxication, sarcoidosis, and prolonged immobilization have also been implicated. White flecks aggregate near the corneal limbus, gradually increasing, and may ultimately involve the entire central surface. It is not uncommon to find a whitish circular band near the limbus at 3 and 9 o'clock in normal patients, so that the diagnosis can only be established when the crystals show signs of extending toward the center of the cornea, or may be easily visualized by the naked eye.

Toxic Disorders

At one time, corneal lesions used to be caused by the use of silver, gold, and arsenic. In these

cases, a typical concentric rim of greyish-brown pigmentation is found near Descemets membrane. The most common of the toxic substances are the antimalarials used in dermatologic and rheumatologic conditions. These drugs, especially in high dose, may affect the corena. Unfortunately, the corneal changes are of no assistance in indicating the development of the more serious retinal changes. A diffuse corneal epithelial or subepithelial haze is the first sign which gradually disappears, leaving a curved vertical or horizontal whitish opacity. The corneal changes may disappear without cessation of treatment, and in most instances do not effect the vision.

A well known corneal change is the Kayser-Fleisher ring, which is seen in the limbal area of Descemets membrane as a copper colored band. This ring is a sign of Wilson disease or hepatolenticular degeneration.

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3825 Kennedy Boulevard

Jet Travel And The Metabolic Clock

Some day we may read a news item, datelined Vienna, with a story like this:

VIENNA—Representatives of the major power blocs met today to begin negotiations which could decide the future of the world. The leader of the Eastern nations appeared rested and confident after his four-day stay here. The West's top representative, however, was unsteady after arriving by jet only last night.

This hypothetical news item illustrates the problem of an added dimension to travel. Intercontinental movement on today's jet aircraft—which can reduce the time for a trans-Atlantic flight to five hours—creates in many individuals a serious confusion of time and space.

The traveler may depart Paris at noon and arrive at 3 p.m. New York time. Actual flight time is seven hours but jet speed—combined with the earth's rotation—can result in such a confusion of meal and rest times that a normal eight-hour workday becomes a 12-hour marathon.

Hubertus Strughold, M.D., professor of space medicine at the U.S. Aerospace Medical Center, Brooks Air Force Base, Texas, calls this confusion "physico-physiologic day-night asynchrony." Observations of travelers on long-distance jet flights, he points out, indicate that 70 per cent are so sensitive to such a phase shift that they develop at least some disorder.

One solution is to schedule an early arrival to allow for adjustment to local time. Another is to adopt the sleep and wakefulness pattern of the place of destination in advance. Another answer to save time safely at both ends of the journey was suggested by Dr. Strughold at a medical symposium in Minneapolis last summer as a challenge to the pharmaceutical industry. He calls for a specific drug which could speed adjustment to the new physical day-night cycle.

Says Dr. Strughold: "Here is a challenge for the student of biorhythmology. To dig deeper into this problem may bring results not only valuable in this specific respect but also for broadening our knowledge about the whole spectrum of biological rhythms."

A wide spectrum of therapies is now available for carcinoma of the prostate; and the outlook is by no means universally gloomy.

A Modern Approach To The Diagnosis And Management Of Carcinoma Of The Prostate*

William A. Milner, M.D./Albany, N.Y.

Historically, carcinoma of the prostate has always been a disease which in most instances could *not* be cured. Only the rare case lent itself well to cure by radical perineal prostatectomy.

Beneventi[1] in a study of cases of solitary hard nodules of the prostate which had come to surgical biopsy has noted that less than one-half of these have been positive for carcinoma. When one considers the number of solitary hard nodules seen in 500 cases of prostatism, it becomes evident that the number of cases which can be considered legitimate candidates for radical surgery is indeed small; and even a small proportion of these will eventually prove to have been inoperable in terms of a cure. Prior to 1932, patients having open surgery for vesical neck obstruction due to cancer almost invariably became obstructed again within a year or so.

With the advent of transurethral surgery, it was noted that most patients with cancer of the prostate did not recur with their obstructive symptoms following transurethral surgery. This came as a great boon, for previously many of these cases had to complete their earthly stay with permanent suprapubic diversion of the urine.

With Huggins' work on hormonal control of cancer of the prostate,[2] another step forward was taken in the care of this disease. Ten years after the beginning of hormonal therapy in the treatment of cancer of the prostate, it became obvious that a certain proportion of patients would then live their lives out and succumb to the normal ravages of life, but would not die of cancer of the prostate. Another—and a small—proportion, treated by adequate transurethral prostatectomy alone would complete their alloted life span without evidence of recurring cancer in their prostatic capsule or elsewhere in their body. These observations made radical surgery, with its attendant complications, seem much less inviting as a treatment for the disease.

In the Albany Medical Center Hospital, 17 to 20 percent of all cases of prostatism have had proved cancer of the prostate. The average age is about 67. There is an interesting observation concerning the relationship of age to cancer of the prostate: a few years ago, I reviewed 1500 cases and noted that 150 of them averaged eighty-three years of age. In this group, the incidence of cancer rose sharply to 36 percent, or roughly double the over-all picture.

The pathology of the gland itself presents an interesting relationship to end results and

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* Read by invitation May 17, 1965, in Atlantic City, at the annual meeting of The Medical Society of New Jersey. Dr. Milner is head of the Urology Department at the Albany Medical College.

[1] Personal communication to author.

[2] Huggins, C.: *Cancer Research*, 1:293 (January 1941)

survival rate. In 85 percent of the cases, the cancer of the prostate will have a definite tendency to gland formation and will be well differentiated. Fifteen percent will be highly undifferentiated anaplastic lesions. As one would suspect, it is in the 85 percent of well differentiated tumors that the best results are obtained by orchiectomy or hormonal therapy. The 15 percent of highly anaplastic lesions will give the poorest results with hormonal therapy.

Treatment

Single, solitary hard nodules, proved to be cancer, are best managed by radical prostatectomy. The gland should be resected as completely as possible. Indeed, the more complete the resection, the better the end-result. Obviously, where the tumor has already perforated the capsule and extended up along the vesicles, the operation need be only sufficient to enable the patient to empty the bladder well. Very few cancers recur in the prostatic urethra after resection. Most of these patients continue to void well throughout the balance of their lives.

In the presence of known metastases, the patient is advised to have orchiectomy at the time of his resection. If he has elevated acid phosphatase and clinical signs and symptoms of metastases, even without x-ray evidence, an orchiectomy is done. Also, in the presence of clinical signs and symptoms of metastases without any urinary obstruction, orchiectomy is done without doing anything to the prostate.

If carcinoma of the prostate is discovered as an incidental finding (without any evidence of metastases) in a gland that was thought to be clinically benign, then only transurethral resection is done and the patient is followed conservatively in the office.

We have followed several such cases, the longest being over twenty years, without evidence of local recurrence of cancer.

All cancer patients must be seen at three month intervals so that if there is any breakdown of the disease it may be diagnosed early and adequate steps taken to control it.

Hormones are used when indicated; and occasionally as a last resort, cortisone is useful in the control of pain. If the gland grows again, or if there is local spread, we have found cobalt radiation therapy to be of value in reducing the size of these local extensions.

In our experience, many of the carcinomas of the prostate which we treat live their lives out and die of other causes rather than their carcinomatous prostates.

Some, of course, reach the end of their rope at about five years and then rapidly disintegrate and succumb to their disease in spite of all efforts on the part of their surgeon to keep them alive.

During one five-year period, 563 cases of cancer of the prostate were seen at the Albany Medical Center Hospital. (See Chart I)

CHART I

	Cases	*Thirty-Day Mortality*	*Percent*
Transurethral resection only	245	5	2.0
Transurethral resection and orchiectomy	231	5	2.2
Biopsy distant site	21	1	4.8
Autopsy only	19	0	0
Clinical with orchiectomy	22	0	0
Clinical only	25	8	32.0
Total	563	19	3.4

The survival rate is readily seen in Chart II.

CHART II

Years	*Percent Surviving*
0-1	75
1-2	60
2-3	46
3-4	35
4-5	27
5-6	19
6-7	16
7-8	14
8-9	10
9-10	5

It must be remembered that many of the patients surviving less than ten years did *not* die of this disease.

Summary

1. For the solitary nodule which is proved to be cancer by biopsy, radical prostatectomy is the treatment of choice.

2. In cancer of the prostate, discovered by chance in doing a transurethral resection, do no further surgery. Watch the patient carefully. If at any time he shows evidence of local recurrence or metastases, then hormonal therapy or orchiectomy is indicated.

3. The patient with x-ray evidence of metastases and with clinical evidence of the disease should have orchiectomy immediately along with his resection if he has bladder symptoms requiring vesical neck surgery.

4. The man having clinical symptoms of carcinoma of the prostate with an elevated acid phosphatase should have orchiectomy as a primary procedure.

5. The patient having carcinoma of the prostate who has been on hormonal therapy and has begun to slip should be checked carefully. If he has normal sized testes, he should have orchiectomy immediately for he is either not taking his medicine or is on an inadequate dose.

6. Carcinoma of the prostate is not nearly the dreadful disease it was thirty years ago, and many of our patients lead long and useful lives after we have discovered and treated their prostatic disease.

7. They all do better if they know the nature of their disease and are told what can be done for it and the great importance of regular check-ups.

Albany Medical College

Narcotic Pamphlet Available

A pamphlet on narcotics—what they are, their uses and controls to prevent abuse—is available now to physicians. Prepared by the Pharmaceutical Manufacturers Association, it is entitled *Medicinal Narcotics—Facts on Benefits and Controls.*

This brochure offers sound information on the role of medicinal narcotics indispensable for the relief of pain. It describes the safeguards established to prevent abuse. The pamphlet reminds the public that "unlawful underworld traffic in heroin and marihuana should not be confused with legitimate distribution of narcotics for medical use." All physicians will be interested in the way this brochure clarifies the confusion arising from the use of the term "exempt narcotic," explaining that an "exempt" narcotic is not exempt from federal controls.

The pamphlet balances the public interest, so that these valuable products are as free from abuse and illegal diversion as possible yet are readily available to persons who need them for the relief of illness and pain. It notes the responsibility of pharmacists, wholesalers, and manufacturers to make certain that no products escape from the legal and moral channels of distribution.

The pamphlet describes a key to effective and efficient enforcement.

For your copy, write to Pharmaceutical Manufacturers' Association, 1155 N.W. 15th Street, Washington, D.C. 20005 and ask for *Medicinal Narcotics: Benefits and Controls.*

For cities in its size bracket, Newark has the highest infant mortality in the nation. Dr. Sachs here outlines the vigorous steps now being taken to meet this challenge.

Task Force For The Future*

Miriam Sachs, M.D./Trenton

Traditionally, major responsibility for mental subnormality has been shared by three disciplines: pediatrics, psychiatry and neurology. In recent years, emphasis on birth injuries and birth difficulties as a cause of brain damage and mental retardation has added the obstetrician to the team concerned with the brain damaged child. Preventive medicine and public health are relatively newly arrived on the scene.

The President's Panel on Mental Retardation[1] asserts that the prevalence of mental retardation is significantly higher in population groups where maternal care is frequently inadequate. Patients with very little or no prenatal care have a prematurity rate twice as high as do women who have had constant, adequate care. The association of low birth weight and the incidence of neurologic disorders and mental retardation is well documented[2]; thus, the prevention of prematurity should have high priority in prevention of mental retardation.[3]

The President's Panel on Mental Retardation has asked for a program with federal funds on a project basis to assist state and local health departments in the costs of administering programs of comprehensive maternal and infant care. In the words of the legislation:

"To help reduce the incidence of mental retardation caused by complications associated with childbearing . . ." grants may be approved for projects which provide ". . . . necessary health care to prospective mothers (including after childbirth, health care to mothers and their infants) who have or are likely to have conditions associated with childbearing which increase the hazards to the health of the mothers or their infants (including those which may cause physical or mental defects in the infants) and whom the state or local health agency determines will not receive the necessary health care because they are from low-income families or for other reasons beyond their control."[4]

The appropriations of federal funds for project grants for maternity and infant care are in the amounts of $5,000,000 for the fiscal year which ended in June 1964; $15,000,000 for the fiscal year ending in June 1965; and $30,000,000 for each of the next three years.

Lesser of the Children's Bureau, commenting on distressingly high infant mortality rates, has accepted his stewardship of these enormous amounts of monies with this statement:

"It is interesting to me, and perhaps characteristic of the way we do things in the United States, that a proposal for legislation to do something about this problem has been developed, not in direct response to the problems of maternity care, but in relation to the current interest in mental retardation."[5]

For the Children's Bureau, eternally vigilant, has been pointing out a curious reversal of trend in infant mortality rates in certain critical areas. Thus, infant mortality rates† have long been emphasized as the most sensitive index of health conditions. It is thought of as a measure not only of public health but of total medical care. During the last 50 years in the United States, there has been an amazing reduction in infant mortality. Infants born today have at least four times better chance of surviving "the dangerous first year" than did

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* Read May 17, 1965 at Atlantic City before joint sessions of Obstetrics and Gynecology, Pediatrics, Psychiatry and Neurology of The Medical Society of New Jersey." Dr. Sachs is the District State Health Officer for the Metropolitan District, New Jersey State Department of Health.

† Defined as "number of deaths, under one year of age, per 1000 live births."

those born in 1915. The infant mortality rate for the United States has leveled-off at 25 to 26 per 1000 although several foreign countries have continued to improve (Australia, Canada, Denmark, and others).

Since the end of World War II, there has been a tremendous shift in population, with lower income groups moving from rural areas to large cities. At the same time, middle class families have been abandoning the cities and have sought homes in the suburban rings. The increasing concentration of low-income families in major cities is straining their medical-care resources. Infant mortality rates in major cities are an accurate mirror of the in-migration of persons in the lower economic, social, and educational levels who are living side by side with those "native" residents of the city who have not the affluence for younger, newer communities. In 1960, nine of the ten largest cities in this country had infant mortality rates that exceeded the national rate. In seven of these ten, the rates increased[6] during 1950 and 1960 by percentages ranging from 5½ to 26½ per cent.

What of New Jersey? The 1960 census revealed that New Jersey was the most urbanized and densely populated state in the nation. Since in size we are fourth smallest, even non-statisticians can predict that certain areas are getting crowded. The largest city in New Jersey has a population of about 400,000 and never makes the lists of the first ten, headed by an overshadowing neighboring municipality whose population is greater than in all of New Jersey. But in 1964, *Newark had the highest infant mortality rate of any city over 100,000* in this country. This dismal fact will assure us of assistance,[7] and therefore hope, for the future.

For several years, the City of Newark and the State Department of Health have been trying to alleviate the conditions caused by the intense demand on the official health services. When *The Maternal and Child Health and Mental Retardation Planning Amendments of 1963* (Public Law 88-156) were enacted, Newark had an infant mortality rate of 41† contrasted with the State rate of 24 and a United States rate of 25.3. The most favorable city rate in New Jersey at that time was 14 (Union Township in Union County). If that rate had applied to the over 10,000 resident births in Newark only 145 babies would have died instead of 431. The goal, then, was saving the lives of 286 babies, the excess infant mortality.[8]

Study and survey of all the ramifications of the problem were conducted by State Health Department staff from Trenton and the District Office in cooperation with the Newark Department of Hospitals, the Newark Department of Health and Welfare, and the voluntary hospitals of Newark. A design was established for a Maternity and Infant Care Project.

Essentially, the primary points emerged as follows:

1. Newark has a population of 405,000 with a female population between the ages of 13 and 20 years of about 22,000.

2. From this populace, Newark City Hospital (formerly Martland Medical Center) is called upon to provide prenatal, obstetrical, and follow-up services for 4,500 cases per year; and to provide premature services to 467 newborns. Follow-up child health conference services for the total newborns are provided by the Division of Child Hygiene.

3. By their own statement they feel that they can now handle, in the proposed project approved manner, only 3,000 such cases per year.

4. At the Newark City Hospital, crowding of the prenatal clinic has been excessive, necessitating prolonged waiting for the prospective mother. Facilities and personnel are too limited to provide adequate care for those attending. Travel distance to this location is another impediment to regular prenatal care.

5. Out-patient visits of obstetrical cases, return visits and post partum follow-up number 16,500 per year with out-patient clinic services for such cases in operation only 4 mornings per week.

6. In 1963, of the total deliveries, 958 children were born out-of-wedlock. In 1964, this number had risen to 1,982. Sixty percent of these births occurred to mothers in the age group 12 to 21. A high proportion of these received little, if any, prenatal clinic services. Counselling, guidance, and family and home visiting were completely lacking.

7. The pediatric and newborn services at Newark City Hospital (102 pediatric beds and 86 bassinets) have inadequate supervision. The position of director of the Pediatric Service is a nonpaid voluntary appointment held part time by the director of Babies Hospital in Newark. There is a teaching liaison between Newark City Hospital and Babies Hospital which provides a

director of Medical Education on one-third time to the City Hospital; the City Hospital budget contributes a third of this salary. Pediatric out-patient service is limited to a small follow-up clinic, staffed chiefly by residents on call. All other pediatric patients are routed through the Emergency Room and are never seen by a pediatrician. Organization, direction, and supervision of the clinic are lacking. The need for a full-time, paid director of the Pediatric and Newborn Services at Newark City Hospital has for some time been recognized by the State Health Department and called to the attention of Newark City Hospital.

8. Professional social work is either nonexistent or scattered and uneven in coverage in the public and voluntary health agencies of Newark. Few Newark social agencies are equipped to deal with medical-social problems, particularly in the culturally deprived, lower economic groups. The social component in adequate maternity care is well documented. A significant increase in the quantity, quality, and continuity of social services for maternity patients is essential to the Project.

Needed care cannot be provided without services organized at the community level to deliver a full range of preventive, curative, and restorative services; and to support and conserve professional skills by making available the supplementary skills which professional personnel cannot be asked to provide.

Far-reaching changes in the staffing of Newark City Hospital were already under way with the creation of several positions for full time directors of services. The most important of these to the Project was the appointment of a qualified chief of the Obstetrics and Gynecology Service and an approved residency program in obstetrics. With, as yet, no additional funds from the Project, this key service has improved tremendously under firm leadership.

To relieve the overcrowding and overtaxing of facilities at Newark City Hospital, it has become vital for the Project to include the voluntary hospitals of Newark in the chain of linked, readily accessible prenatal, obstetrical, and postnatal services. Voluntary hospitals in Newark, as elsewhere, are faced with rising *per diem* costs and the discrimination of third party payment plans against out-patient services. Welfare payments have not kept pace with rising costs. Many of its regulations force patients out of the voluntary hospitals and into the municipal hospital. Project funds, a program of comprehensive maternity care (not just a demonstration) can be utilized to reimburse for clinic visits, hospitalization for obstetrical care, and for hospital care for premature infants and others requiring special care. A basic flat fee for hazard cases has been evolved at $250 per case: $10 per clinic visit for 10 prenatal visits ($100) plus $30 a day for 5 days of hospital care for mother and newborn. Each participating voluntary hospital may use this reimbursement to meet standards, under its own pattern of staffing.

In addition to funds, one qualified senior social worker will be assigned to each participating hospital and two public health nurses will assist in staffing out-patient sessions to maintain continuity of care.

The five participating hospitals in the Project, in addition to Newark City Hospital, are: Newark Beth Israel, Newark Presbyterian (United Hospitals), St. Michaels, Columbus, and St. James.

For smooth functioning of in-hospital and in-community services and to build a sound under-structure, it became mandatory to effect a radical revision of Newark's public health services. A new division of Family Health Services was created with a full-time Medical Administrator as its head. A second critical position, a director of Public Health Nursing, was also established to generalize, for family-centered nursing, the public health nurse complement. These two positions are entirely in the City of Newark budget. So historic are these steps that they are recorded here.

On July 9, 1964, the Municipal Council directed the City Clerk to request from this office (director of Health and Welfare) legal changes necessary to implement the proposed reorganization of official public health services.

The extensive reorganization of services was presented to the City Council and had its first reading and approval April 7, 1965; and its second and final reading and approval April 21, 1965. Twenty days after April 21, the ordinance became effective (May 11, 1965). The text of the ordinance follows:

1. That Article XIV, Department of Health and Welfare, of the Revised Ordinances, 1951, as amended, be supplemented by the following section:

Sec. 2.143-A Division of Family Health Services

There shall be within the Department of Health and Welfare, a division of family health services, the head of which shall be a physician certified by the American Board of Preventive Medicine and Public Health and with at least five years of full-time experience with responsibility for administering health services in a recognized agency. The division of family health services shall provide:

(a) Maternal and child health services, including infant and pre-school health services, health services in parochial schools, and health services for handicapped children.

(b) Dental health services.

(c) Preventable disease control services including communicable disease control, tuberculosis control, and venereal disease control.

(d) Chronic disease control services.

(e) A generalized public health nursing service.

(f) Medical social work services.

(g) Appropriate clinics as required by the several division programs.

(h) Laboratory services.

(i) Health advisory services, including health education and nutrition.

2. This ordinance shall take effect upon final passage and publication.

After 18 months of study, planning, and conferences—of opposition and of support—of reluctance on the part of some, and eagerness on the part of others to participate in this all out effort, the Project can announce its objectives. They are to:

1. Provide a full-time Director of Pediatrics at Newark City Hospital.

2. Afford readily accessible, high caliber prenatal, obstetrical, postpartum, premature nursery and continuous infant and child care services to persons who would not, ordinarily, be able to purchase this type of service.

3. Reduce the caseload of such services at Newark City Hospital by approximately 2,000 cases.

4. Distribute this excess caseload among the five other Newark voluntary nonprofit hospitals. This distribution will be made as relates to the location of the hospitals and the caseloads, based upon census tract studies.

5. Assist in enhancing the services in all six hospitals through consultation services from present State Program staff and through direct services from proposed Project staff.

6. Expand the premature services at Newark City Hospital and afford consultation to the premature services of the other hospitals in the program as well as services for direct transfer of such cases to Newark City Hospital when indicated.

7. Provide consultation, guidance, and direction through medical-social services and nursing followup to those who need them with particular emphasis as relates to unwed mothers.

8. Work with the Newark City Department of Health and Welfare (Division of Family Health Services) in affording better Child Health Conference services for followup of all newborns as a result of this project.

9. Establish a separate facility for continuity of counseling and guidance to young mothers (both married and unmarried) through the medium of a Child Health Conference staffed to meet their particular needs.

10. Alleviate such deterrents to adequate medical care throughout the prenatal and postpartum periods as may be posed by the demands of the home situation or expense and inconvenience of travel, through the provision of such ancillary services as Homemakers, bedside nursing care, and defraying costs of patient transportation.

11. Afford a health education program for the community from which these patients come.

12. Provide dietary counseling to patients in the Project, and nutrition consultation to the cooperating hospitals and nutrition education to public health nurses.

13. Assure dental service as necessary to mothers registered in prenatal and postpartum clinics at Newark City Hospital and the cooperating voluntary hospitals.

A project coordinator has been assigned by the State Department of Health. She is a board pediatrician with a Master of Public Health degree and five years experience as district consultant pediatrician for the Metropolitan State Health District. She has the almost impossible assignment of coordinating the policies and procedures of the Children's Bureau, the State Department of Health, and all the Newark components of the project.

These are the tools to work towards a better future for the disadvantaged. This is the best we know how to do to help prevent the conditions concerned in the etiology of brain damage and mental retardation.

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P.O. Box 1540

STATE ACTIVITIES

MSP Benefits For Non-Participating Physicians

The following statement is made by Society's Legal Counsel at the request of the Board of Trustees, in an effort to clarify any misunderstanding which may have arisen as a result of the recent action taken by MSP.

Under date of October 27, 1965 the secretaries of all component medical societies were advised in detail concerning the action taken by the Board of Trustees of The Medical Society of New Jersey at its meeting on October 17, 1965 with regard to inquiries made by certain members of The Medical Society of New Jersey concerning the policy set forth in the Series 1965 Blue Shield (Medical-Surgical Plan of New Jersey) subscription certificate pertaining to the non-assignability of subscriber payments for medical services rendered by non-participating physicians.

The advice conveyed by the letters reporting the action of the Board of Trustees was to the effect that the policy determination of MSP was neither illegal, improper, coercive, nor discriminatory. The subscriber certificate issued by MSP is a contract between MSP and the subscriber, and each is bound to the terms stated therein. All of those terms are subject to the scrutiny of the Commissioner of Banking and Insurance prior to issuance. The 1965 Series was examined in detail and approved by the Commissioner of Banking and Insurance with full knowledge of the fact that "benefits and payments . . . are personal and not assignable." Prior to approval, the Commissioner determined that no statutory reason exists for disapproval. The Commissioner himself is aware of the fact that participating physicians in effect make a sacrifice for the benefit of all subscribers which is not made by non-participating physicians, and that therefore it would be improper for the non-participating physician to receive all of the benefits received by the participating physician (direct payment by MSP), particularly since, for subscribers in the specified income categories, the participating physician accepts MSP payment as full payment whereas the non-participating physician considers it as only a partial payment.

In 1953, the House of Delegates approved in principle a proposal submitted by MSP that "payment of any Plan benefit be made only to the Subscriber, for eligible services rendered by a non-participating physician practicing in the State of New Jersey." In 1954 and in 1955, the House again approved that proposal as a component of the annual report of the Medical-Surgical Plan.

The Board of Trustees of The Medical Society of New Jersey has been fully appraised by the President of Medical-Surgical Plan of New Jersey concerning the action taken and concerning complaints submitted by a small group of physicians. The Medical Society of New Jersey is in no way in disagreement with the action taken by MSP; and, in fact, has through the years approved proposed changes to a similar effect.

It is for the above reasons that the Board of Trustees of MSNJ has approved in principle the direct payment to the Subscriber for professional services rendered by non-participating physicians, and likewise has recorded itself as favoring the action of MSP in declaring as non-assignable payments to non-participating physicians.

It is interesting to note that in a recently published report on a study of the United Medical Service Blue Shield Plan of New York City (by the New York Labor-Management Council of Health and Welfare Plans, Inc.) one of the eight recommendations offered as a challenge to Blue Shield to make good its promise as a community pre-payment plan of a high order reads as follows:

"UMS should take steps to increase physician participation by no longer honoring assignments of fees to non-participating doctors . . ."

The only litigation on the question of non-assignability which has come to my attention is a Wayne County, Michigan, Circuit Court matter pertaining to a temporary restraining order against Michigan Medical Service instituted by the Commissioner of Insurance of Michigan which resulted in a consent judgment covering numerous points, only one of which was a specific prohibition against any assignment from a patient to a physician.

Trustees' Minutes

October 17, 1965

A regular meeting of the Board of Trustees was held on Sunday, October 17, 1965, at the Executive Offices. For your fuller information, detailed minutes are on file with the secretary of your component society. A summary of the signficant actions follows:

Medicare Program . . . Approved the following organizational steps, in consequence of the enactment of the Medicare Law:

1. Assign to the Council on Medical Services overall responsibility to study and provide recommendations concerning (1) all aspects of the Medicare Program as it will operate in New Jersey, and (2) the maintenance of quality medical care.

2. Recommend the formation within the Council on Medical Services of subcommittees to deal with specific areas of Medicare concern; e.g., (a) utilization review procedures, in hospital and out; and (b) steps to effect satisfactory implementation of medicare in New Jersey, especially under Title XIX, by either legislative enactments or administration assignments or regulations.

3. Name as consultants to the Council on Medical Services the President, President-elect, Chairmen of the Councils on Legislation and Public Health, Chairman of Committee on the Chronically Ill and the Aging, Chairman of Joint Council to Improve Health Care of the Aged, and Dr. Frank Hughes (member of New Jersey Board of Control).

4. Transfer the Committee on the Chronically Ill and the Aging to the Council on Medical Services from the Council on Public Health.

5. Supply the services of the legislative analyst—as an extra duty separately contracted for—for the information and guidance of the Council on Medical Services in its deliberations.

Health Facilities Council . . . Nominated Dr. John F. Kustrup of Trenton to the Board of the Health Facilities Planning Council, to fill the expired term of Dr. Louis S. Wegryn.

MSP Non-Assignment Policy . . . Approved the following report, and took the actions indicated:

A communication from MSP President, Dr. Alfano, reported that numerous objections have been raised by physicians, or by legal counsel in their behalf, to the new subscription certificate which makes a non-assignable payment directly to the subscriber when services are rendered by a non-participating physician. Several of the letters received indicated the possibility that legal action may be taken against the Plan. They allege that the new ruling is improper, coercive, discriminatory, harassing, and generally objectionable, insofar as it affects non-participating physicians. . . .

The MSNJ House of Delegates in 1953 approved proposed changes in the MSP contract. The 8th proposal read "that payment of any Plan benefit be made only to the subscriber for eligible services rendered by a non-participating physician practicing in the State of New Jersey." This same change was included in the 1954, 1955, and 1956 reports of MSP to the House of Delegates, all of which were approved. The 1957 MSP report to the House of Delegates announced the conversion from the series 1949 contract to the series 1956 contract, listing as one of the major changes in the series 1956 contract: "the Plan may make payment to the subscriber when the patient is attended by a physician who is eligible to be, but is not, a participating physician." Further, a resolution from the Union County Medical Society to the 1957 House of Delegates, calling for MSP to be placed on an indemnity basis for all subscribers, was disapproved by the House for the reasons that:

(a) Beyond the limits of a $5,000 single income and $7,500 combined income, MSP becomes an indemnity plan.

(b) For non-participating physicians, it is in essence an indemnity plan.

(c) In this inflationary period, the $5,000 to $7,500 income bracket is a proper group to have in a service plan.

(d) Any effort to change the present MSP from a service type of plan to an indemnity type of plan would necessitate complete dissolution of present MSP.

Legal Counsel reported that, as a result of a question raised at the preceding meeting of the Board, he had conferred with a representative of the State Department of Banking and Insurance, who stated that the amendment to the contract has been properly filed and approved after an investigation which determined that there was no statutory reason why the amendment should not be approved.

Legal Counsel further stated that of the 22 Blue Shield Plans which make non-assignable payments to subscribers for services rendered by non-participating physicians, he knows of no legal action having been taken.

An explanatory reply by Dr. Alfano to one attorney was read for the Board's information. The Board agreed that the detailed information in this reply should be brought to the attention of the membership.

It was pointed out that when the subscriber accepts his contract he in effect waives his right to assignment of payment for services rendered by a non-participating physician.

The Board of Trustees, after careful study of the information supplied by MSP, and in view of the previous actions of the House of Delegates approving in principle payment directly to subscribers for professional services rendered by non-participating physicians, recorded itself as favoring the action of MSP declaring as non-assignable payment to non-participating physicians. That the members of MSNJ may understand the thinking underlying its actions, the Board directed that a clarifying explanation to the membership be issued as early as possible. The Board therefore directed:

1. That an extract of the pertinent facts of the correspondence supplied by Dr. Alfano be sent to the secretaries of the component societies with a request that they bring these facts to the attention of their members.

2. That a copy of the communication to the county secretaries be sent to the members of the Board of Trustees.

3. That a clarifying explanation of the matter, prepared by the Society's legal counsel, be published in an early issue of THE JOURNAL.*

4. That an item of reference to THE JOURNAL explanation be published in the next issue of the *Membership News Letter.*

Medicare Law . . . Authorized the distribution of a pamphlet to each member of MSNJ on "Health Insurance for the Aged—Questions and Answers"; urged the membership to follow the AMA NEWS, which will be utilized as the media of information on implementation of the Medicare Law.

Juveniles and Venereal Disease . . . Directed that the opinion of the Attorney General concerning the treatment of juveniles for venereal disease without the permission of the parents be brought to the attention of the entire membership:

The relation of physician and patient is consensual. Therefore, the treatment without consent is a matter of civil liability except in special situations where consent of the patient is not necessary; e.g., emergencies under the "Good Samaritan Law."

Under the present law, therefore, any physician treating a juvenile for venereal disease without the consent of the parent is liable to civil action.

Suggested that the Council on Legislation, in cooperation with the State Department of Health, study the desirability of amending legislation.

Current State Legislation . . . Considered the following bills of medical import from the Council on Legislation and took the actions indicated:

S-352—To increase the number of members on the Air Pollution Control Commission to 11 members in place of 9 and to provide for 3 public members in place of 1. *Approval*

A-716—To hold guiltless persons who injure another while rendering assistance to prevent the commission of a misdemeanor or high misdemeanor against the person of another and to provide that person who fail to render or obtain assistance is a disorderly person. *Approval*

A-730—To provide that if a podiatrist (chiropodist) is authorized by law to perform the particular medical or surgical services, he shall be entitled to compensation for such services under the Workmen's Compensation Law. *Approval*

A-734—To reorganize and continue an eleven member Air Pollution Control Commission in the State Department of Health. *No Action* . . . in view of approval of S-352

A-736—To require the county prosecutor to initiate an investigation of physical abuse of children immediately upon receipt of a telephone or other report from a physician. *Approval*

A-739—To create the New Jersey Hazardous Substances, Labeling Act. *Approval*

A-750—To exempt from taxation any equipment, facility or device used primarily for the purpose of abating or preventing pollution of the atmosphere. (Substitute for S-171 (laid over) . . . concerning which the Society's position is one of approval.) *Approval*

A-812—To establish control over the sale of firearms to persons who have ever been committed to mental institutions, who are under age 18, who suffer from a physical defect, who have ever been convicted of a crime, who are alcoholic or narcotic addicts, who are nembers of a subversive organization. *No Action*

Adopted the recommendation of the Council on Legislation that the following bills be *noted and filed,* as not being of concern at this time.

S-348—To provide for the continuation of hospitalization, medical surgical and major medical insurance for retired members of a City Employees Retirement System in cities of the first class.

SCR-20—To commend the Board of Trustees of the Hunterdon Medical Center for naming the in-

* See page 565 of this issue.

tensive care facilities under construction at the center as a memorial to the late Senator Raymond E. Bowkley and to pledge active support in the campaign to equip the memorial.

A-684—To remove the requirement of giving color and nationality in reporting a person infected with a venereal disease, or of a person bitten by a dog; to delete the requirement of submitting two signed photographs in applying for a barber's license.

Concurred in the opinion of the Council on Legislation that it was not necessary to take an official position concerning the following bills, because they were introduced since the last meeting of the Council and were disposed of as indicated:

S-302—To increase workmen's compensation benefits. (*Lost in Assembly*)

S-332—To provide immunity from liability to respond in damages as a result of acts rendered in good faith providing emergency first-aid and rescue services to paid police and fire department members. (*Lost in Assembly*)

S-334—To provide 180 days in place of 90 days for completion of required medical examinations for volunteer firemen required under P.L. 1964, c 291. (*Signed into Law—Chapter 65*)

A-707—To permit freeholders to appropriate annually a sum not exceeding $12,000 to any non-profit, nonsectarian corporation which operates occupational training center for mentally and physically retarded and disabled persons. (*Signed into Law—Chapter 109*)

"Pap" Smear Test . . . Disapproved the recommendation of the Special Committee on Cancer Control that "all female hospital in-patients and new admissions routinely have 'pap' smear tests" in view of the prior approval of the committee's recommendation "that a thorough and systemic examination for cancer detection be made by private physicians."

Pre-School Vision Testing . . . Approved the recommendation of the Committee on the Conservation of Vision that the State Department of Health be informed of the Society's interest in, and support of, a program for the vision testing of pre-school children at "Well-Baby Clinics," with the Society's recommendation to the Department that it issue instruction cards to the clinics listing the following:

1. If vision in one or both eyes is found to be less than 20/40, the child should be referred to a hospital clinic where there is an ophthalmologist, or to an ophthalmologist in private practice.

2. Although the test is primarily directed at amblyopia ("sleepy eyes"), it is important to refer the child to an ophthalmologist if any abnormal eye signs are detected.

Pre-School Screening Pamphlet . . . Accepted the offer of the State Department of Health to underwrite the cost of publication of a pamphlet prepared by the Committee on the Conservation of Vision which outlines instructions for personnel and mothers to educate children in preparation of screening of pre-school children.

Major Medical Insurance . . . Approved the following report of the Committee on Medical Defense and Insurance:

The committee considered a communication from Mr. Blanksteen outlining modifications of coverage as well as increase in rate for the Major Medical Insurance Program:

1. The maximum limit of coverage will go from $10,000 for any one disablement to $15,000. The exception to this will be a reduction from $10,000 to $2500 for disablements caused by mental diseases.

All other major medical policies we have seen in effect for professional groups have always had a limit of $1500 or $2000 for disablements due to mental disease. We now realize that we were off base by being the exception and providing coverage up to $10,000 for such disablement. We have found that the other companies were right and we were wrong and, therefore, mental diseases will be limited to $2500, which is still better that that found in the group policy of the average company.

2. Nurses will be limited to $37.50 per diem but the policy will be extended to include licensed practical nurses in the hospital in addition to R.N.'s. For coverage out of the hospital, R.N.'s only.

The increase in premium is 40%. The company has continued to lose money on major medical. Actual claim losses plus reserves is 96% and with claim expenses and other administrative costs, overall costs run 125%.

In order to keep ahead of rising hospital costs, it is suggested that new members who apply within 60 days of their election to membership be taken into the group, regardless of their own physical impairment, but that coverage of their dependents be on a selective basis. Heretofore, dependents who have impairments have not been excluded. The policy of coverage on a selective basis for those who apply after 60 days after election to membership will be continued.

The committee approved the modifications of coverage as outlined by Mr. Blanksteen, and approved the suggestion that coverage of new members be limited to the physicians themselves, regardless of whether they have an impairment, but that their dependents be covered on a selective basis.

New York Insurance Company . . . Directed that the following information be brought to the attention of the membership through their component societies:

The committee considered several requests for information on the Professional Insurance Company of New York relative to malpractice insurance coverage. The inquirers noted that PIC rates are about 30% less than those of American Mutual. A copy of the reply made by American Mutual to such inquiries was reviewed. The committee approved the suggestion that this same reply be made to inquiries received by the Society, and further, that the reply be distributed to the component societies for their information and for their use in the event that inquiries are directed to them.

Bicentennial General Sessions . . . Approved the following program, as recommended by the Annual Meeting Committee: "The Medical Society of New Jersey—An Historical, Scientific, and Civic Appraisal." Dr. Morris Fishbein to speak on the Historical Appraisal; Dr. James Z. Appel to speak on the Scientific Appraisal; and the Governor of New Jersey to speak on the Civic Appraisal.

Section Speakers . . . Approved the following actions of the Annual Meeting Committee in conjunction with section speakers at the bicentennial celebration:

Section officers will be urged to limit each session to three outstanding speakers, allowing each speaker 30 minutes, with 30 minutes allocated for question and answer period(s). It was further agreed that four speakers would be acceptable, if it is felt that the program required this number, allowing each speaker 20 minutes, with 40 minutes allocated for question and answer period(s).

The committee agreed that there were to be no formal discussors of papers.

For 1966 only, the committee agreed that the requirement that the number of guest speakers shall not exceed the number of member speakers should be waived; also that the expense allowances for guest speakers should be expanded so that they can be invited to stay over for the Bicentennial Day as guests of the Society.

County Presidents . . . Invited county presidents to meet with the Board of Trustees on the morning of Sunday, November 14, to facilitate their attendance at the special meeting of the House of Delegates that afternoon.

Declassification of Physicians' Jobs . . . Directed that the State Civil Service Commission be informed that the Board of Trustees has considered the proposed declassification of county and municipal positions that require physicians and dentists and the Board has no objection to the proposal so long as it will not be effective retroactively for incumbents in their present status or advancement to higher office.

Woman's Auxiliary . . . Approved the recommendation of the Annual Meeting Committee that the Woman's Auxiliary be requested to integrate its annual meeting program with the program of MSNJ, and to forego some of its regular meetings in order that Auxiliary members will be free to join in certain sessions of the Bicentennial Program.

General Session on Medicare . . . Revised the annual meeting schedule to include—in substitution for the session on Medicine and Religion—a General Session on Medicare, with a small panel of speakers (representatives of the Social Security Administration and the AMA), followed by a question and answer period.

Tetanus Immunization . . . Adopted the recommendation of the Committee on Disaster Medical Care that those counties which do not have continuing tetanus immunization programs be urged by MSNJ to take measures to effect such programs.

Liability Panel . . . Adopted a revised version of the Proposed Professional Liability Panel for submission to the House of Delegates, at a special session* in November.

Graduate Training Programs . . . Discussed the AMA questionnaire on administrative support of graduate training programs which was recently mailed to hospitals with approved internships or residencies. This questionnaire had questions dealing with salaries to interns and residents through contributions from, or contracts with, the attending staff; and took the action indicated.

Since 1961, the New Jersey delegation to the AMA has fought for the principle that the payment of interns

* See page 571 for House actions.

and residents in hospitals is the responsibility of the hospital and not of the attending staff. The AMA House of Delegates, at its annual meeting in 1963, recorded itself "as opposed to any system or program by which any part of an intern's or resident's salary is paid out of fees collected by the attending physician or out of fees collected under any type of medical-surgical insurance coverage." This position of the AMA has been affirmed and reaffirmed by the AMA. It was the Board's opinion that the leading questions in the questionnaire, which was addressed to hospital administrators, are an open invitation to the administrator to take steps for payment of interns and residents through funds contributed by the attending staff; and that reference in the questionnaire to the subject is in complete disregard of the actions of the AMA House of Delegates.

The Board directed that a letter be sent to the AMA Board of Trustees protesting the questionnaire and requesting that it be withdrawn and the matter be brought under control. The Board is to be reminded that the AMA House of Delegates is on record as opposed to the payment of house officers' salaries out of fees collected from the attending staff; and in certain portions of the questionnaire there is implication that this method of compensation would be acceptable. MSNJ requests that the council withdraw the questionnaire or discontinue its inquiry in this area.

If a satisfactory response is not received from the AMA Board, a resolution will be introduced at the AMA Clinical Session next month by the New Jersey delegation.

Dr. Herschel S. Murphy . . . Noted, with regret, the recent sudden death of Dr. Murphy who, for many years, served as member of the Annual Meeting Committee and as Chairman of the Committee on Scientific Program; authorized a contribution to the Medical Student Loan Fund in the amount of $20 in memory of Dr. Murphy from the Board; appointed Dr. Robert E. Verdon of Bergen County to fill Dr. Murphy's unexpired term on the Annual Meeting Committee until the 1966 Annual Meeting.

Medical Self-Help In Civil Disasters

New Jersey has been one of the leaders in the Medical Self-Help Training Program in the Nation and is the leader in Civil Defense, Region I. This has come about because of the active sponsorship of this program by The Medical Society of New Jersey in cooperation with the New Jersey State Office of Civil Defense. Our leadership can be maintained only with active cooperation by every New Jersey physician until at least one person in every family has completed this program in every municipality in our state.

Medical Self-Help is designed to provide information and training that will help people prepare them for survival in a time of a major disaster when the services of a physician or other allied health personnel are not available.

Everyone capable of learning a few fundamentals can be taught Medical Self-Help which may save lives following a disaster. The course consists of 16 hours of instruction in radioactive fallout and shelter, healthful living in emergencies, artificial respiration, bleeding and bandaging, fractures and splinting, transportation of the injured, burns, shock and nursing care of the sick and injured. Infant and child care and emergency child birth are optional.

All necessary materials and equipment for instruction are in a "Training Kit" that includes a 35 millimeter projector and color film strips, lesson books, instructor's guide, reference manuals, and examination booklets.

The instructor is usually a lay person, such as teacher, Red Cross personnel, or first-aid squad member. The student may be any age from the high school pupil to the elderly person.

The course is free to anyone who wishes to take it or instruct. There is no charge for the training kits or the student material. The local civil defense office implements and administers the program.

To secure the necessary support, all high schools and industrial, church, civic, welfare, and farm organizations must be asked to play a supporting role and actively participate in the organization of classes.

HOUSE OF DELEGATES

Special Session
November 14, 1965
Notre Dame High School
Trenton

The House of Delegates met on Sunday, November 14, 1965, at 2:00 p.m. at the Notre Dame High School in Trenton. Of the 362 accredited members of the House (1965 list), 273 representatives attended the meeting—75 per cent.

The meeting was called as a result of the following recommendation of Reference Committee "A", adopted by the 1965 House of Delegates:

> That the Proposed Professional Liability Panel Program be referred back to the Board of Trustees and appropriate committees for further study, and for the purpose of being put in a final completed form, and further that this matter then be brought again before the House of Delegates for consideration.
>
> However, should it become necessary to act before the next annual meeting, that a special session of the House of Delegates be called to consider this. It is suggested that those delegates who feel that they have worthwhile suggestions make these known in writing to the Board of Trustees and/or the committees working on this matter.

The Board of Trustees, at its reorganization meeting on May 19, 1965, referred the proposal back to the Conference Committee with the Judiciary and the Bar for reconsideration, in line with the action of the House of Delegates. The Board also directed that a copy of the proposal be brought to the attention of the members through the *Membership News Letter* and their constructive comments and suggestions be invited. The proposal and request for constructive comments and suggestions were published as a supplement to the June 1965 issue of the *News Letter*.

The conference committee met several times; conferences were held with the Administrative Director of the Courts; and the Board of Trustees carefully considered each report submitted. At its meeting on October 17, 1965, on recommendation of the conference committee, the Board approved a revised version —which subsequently was approved by the Supreme Court—and directed that it be submitted to the House of Delegates for action. This was in keeping with the hope of the Supreme Court that the program become operative by January 1, 1966.

In his introductory remarks before the House, Society's Legal Counsel (Robert M. Backes) had this to say concerning the Proposed Professional Liability Panel Program:

> To my way of thinking, The Medical Society of New Jersey at this special meeting of the House of Delegates is about to take two giant steps on the path of improved relations with the courts of New Jersey which will, in time, have far-reaching favorable effects upon those of us concerned with the growing number of professional liability or malpractice cases.
>
> The committee which the Board of Trustees of The Medical Society of New Jersey charged with the responsibility of inquiring into the feasibility of a Professonal Liabilty Panel has thoroughly concerned itself with *all* of the ramifications of that matter under the careful guidance of its chairman, Dr. Marcus H. Greifinger. Through the years, it has met repeatedly with the special committee appointed by the Supreme Court of New Jersey, chaired originally by Judge Alfred C. Clapp, Judge Alexander P. Waugh and more recently by Judge Walter L. Hetfield. Joint meetings of these committees resulted in a proposal last year which was turned down by the Supreme Court because of a weak recommendation made by the Supreme Court Committee. Since then many refinements have been made—and frankly, most of them have been in accordance with the physicians' wishes. As a result, we now have for consideration today a proposal which we know, in advance, has the approval of the Supreme Court and the Administrative Director of the Courts. It would, then, if favorably considered by the House, shortly thereafter become a Rule of the Courts, and a mechanism available for use as desired hereafter on a state-wide basis.
>
> It should be known by you prior to its consideration for action that the Supreme Court has leaned over backwards to favor the physicians, even over the objections of the Bar, because of its awareness of the fact that the proposal cannot work without the cooperation of the members of this Society. The Supreme Court has, in fact, conceded certain points to MSNJ with the realization that our insistence may result in a reluctance on the part of the Bar to resort to its use. (Particular reference is made to that provision which requires any attorney to withdraw from a case where the sub-panel has determined that "no reasonable basis exists for the claim"—paragraph 14.)
>
> It should be thoroughly understood that your Board of Trustees is quite aware of certain weaknesses inherent in the system proposed, stemming from the fact that although the Medical Society will provide a medical witness from a previously selected panel of experts

to any claimant who agrees in writing not to carry his matter to litigation, or to terminate existing litigation, such claimant cannot be held strictly to this prior agreement since to do so would be a denial of his right of recourse to a court of law and contrary to public policy. In spite of this weakness, however, and the fact that we can take satisfaction in the realization that under such circumstances the claimant's attorney himself will withdraw, it is my strong feeling that such a written agreement will carry a strong moral obligation which will be effective in many instances.

After careful consideration of all of the provisions and far-reaching effects of the proposal, it is deemed important that you know that the Board of Trustees of The Medical Society of New Jersey feels that the Society will benefit from the ultimate Rule of the Supreme Court in the following manner:

1. It will eliminate the unfounded charge that there exists among physicians a conspiracy of silence which is impenetrable.

2. It will tend to avoid the use, in malpractice cases, of out-of-state medical witnesses which is currently being employed greatly to our disadvantage.

3. It will reduce, by settlement, the number of litigated malpractice cases.

4. It will clearly establish better rapport between medicine and the law.

The House of Delegates formally adopted the proposed Professional Liability Panel, as follows:

PROFESSIONAL LIABILITY PANEL

Statement of Purpose and Intent

1. A professional liability panel to evaluate medical negligence claims shall be established by rule of the Supreme Court with the cooperation of The Medical Society of New Jersey to function on an experimental basis for an indefinite period in all counties.

2. It is understood by the members of both professions that there can be no legal sanction against a claimant who breaches an agreement not to institute legal proceedings or to drop pending litigation.

3. The Medical Society of New Jersey cannot assure what opinion will be given to a claimant by any physician made available under Section 13. It will invite the physician's participation as a qualified medical expert but without prejudice as to his report and testimony.

4. This proposal will not become effective unless adopted as a rule by the New Jersey Supreme Court.

Outline of Proposed Professional Liability Panel

It would appear to be in the common interest of both the medical profession and the legal profession that some procedure be devised (A) to discourage baseless professional liability cases and (B) to make expert medical testimony available in those professional liability cases where there is a reasonable basis for the claim. To accomplish these objectives, the following program is suggested:

1. A professional liability panel to evaluate alleged medical negligence claims shall be established by rule of the Supreme Court with the cooperation of The Medical Society of New Jersey to function on an experimental basis for an indefinite period in all counties.

2. The panel shall be composed of a number of doctors designated by The Medical Society of New Jersey and a number of attorneys designated by the Supreme Court. Men appointed to the panel should be of high standing with broad professional backgrounds rather than men highly specialized in particular fields.

3. Where a claim is submitted to the panel for evaluation it shall be referred to a sub-panel composed of two doctors, two attorneys, and a retired Justice of the Supreme Court, or a retired Judge of the Superior Court or County Court who shall be designated as Chairman. The Chairman shall have a right of vote only in case of a tie.

4. The identity of the sub-panel shall not be made known to either the person submitting the claim or to the doctor against whom the claim is made prior to the actual hearing.

5. The sub-panel shall be named by the Administrative Director of the Courts, from lists of doctors furnished by The Medical Society of New Jersey and attorneys designated by the Supreme Court. The place and time of hearing shall be fixed by the Administrative Director of the Courts.

6. All persons claiming damages by reason of injury or death resulting from alleged medical negligence shall be encouraged by every available means to make an informal and voluntary submission of their claim to the panel for evaluation either prior to or after the institution of legal action. It is preferable that submission be prior to the commencement of action.

7. When such a claim has been submitted, the doctor concerned shall be notified and both the claimant and the doctor shall be invited to submit to the panel any information relevant to the claim.

8. The sub-panel shall hold a hearing on the claim. The claimant and his attorney may attend. The doctor, his personal counsel and counsel for his insurance carrier may attend.

9. The claimant shall set the facts before the sub-panel in whatever form he thinks appropriate. He can do it in the form of a narrative statement by his lawyer. He can do it in the usual courtroom form of question and answer. He can do it by written statement if he prefers. He may call witnesses if he prefers, or he may present sworn or unsworn statements of witnesses. The procedure shall be informal.

With the consent of claimant, the doctor or his attorney (personal or insurance) may question the claimant or a witness.

When the claimant has finished with his presentation, the doctor may in like manner put forth his version of the facts in any form he thinks appropriate.

With the consent of the doctor, claimant's attorney may question the doctor or his witness.

10. Both parties, through their respective attorneys, shall consent to the production of all necessary hospital and other records necessary to a full presentation of the facts.

11. After an evaluation of the information submitted, the sub-panel shall advise the claimant and the doctor only as to whether, in its opinion, there is a reasonable basis for the claim. Its report shall state either "We find that there is a reasonable basis for the claim" or "We find that there is not a reasonable basis for the claim." No opinion shall be given with respect to the extent of damages.

12. When the sub-panel advises that there is no reasonable basis for the claim, it shall recommend to the claimant either that no legal action be instituted, or, if legal proceedings are pending, that they be discontinued. When the sub-panel advises that there is a reasonable basis for the claim it shall recommend that an amicable settlement of the claim be considered.

13 (a) The claimant *may* (but need not) agree in writing in advance not to institute legal proceedings or to dismiss any proceedings that may be pending in the event the sub-panel is of the opinion that there is no reasonable basis for the claim.

13 (b) If the claimant does agree in writing, as provided in paragraph 13 (a), and if the sub-panel is of the opinion that there is a reasonable basis for the claim, it shall be agreed in advance that the Administrative Director of the Courts will supply the names of three expert medical witnesses from a list compiled by The Medical Society of New Jersey, all or any to serve at a reasonable fee to be paid by the claimant.

14. In the event the sub-panel is of the opinion that there is no reasonable basis for the claim, the attorney for the claimant shall be precluded from initiating any action on behalf of the claimant or, if an action has previously been instituted, he shall withdraw therefrom.

This shall not prevent the claimant from obtaining other counsel, if he so desires.

15. All proceedings, records, findings and recommendations of the sub-panel shall be confidential and shall not be used in any other proceeding or be otherwise disclosed without the consent of all parties. All proceedings shall be *in camera* and no record shall be made thereof. All exhibits shall be returned at the conclusion of the proceeding to the parties submitting them.

16. The circumstances under which an expert medical witness was made available, or the fact that he was made available under this plan, shall not be made known to the trier of the facts.

17. The sub-panel may grant a single re-hearing of any claim, under the same conditions controlling the initial hearing, upon the affirmative votes of three members of the sub-panel, exclusive of the chairman.

A re-hearing of any claim shall not be granted if the claimant or doctor has substituted counsel.

Chairmen of Councils and Committees 1965-1966

Air Pollution	Roslyn Barbash, M.D.
Annual Meeting	Jerome G. Kaufman, M.D.
Cancer Control	John L. Olpp, M.D.
Child Health	Robert E. Jennings, M.D.
Chronically Ill and Aging	Matthew E. Boylan, M.D.
Conservation of Hearing & Speech	Warren E. Crane, M.D.
Conservation of Vision	Ralph E. Siegel, M.D.
Credentials	Marcus H. Greifinger, M.D.
Disaster Medical Care	Jack R. Karel, M.D.
Finance and Budget	Thomas C. DeCecio, M.D.
Honorary Membership	F. Clyde Bowers, M.D.
Legislation	Jesse McCall, M.D.
Maternal and Infant Welfare	John D. Preece, M.D.
Medical Education	Sherman Garrison, M.D.
Medical Defense and Insurance	Daniel F. Featherston, M.D.
Medical Services	Nicholas E. Marchione, M.D.
Medical Student Loan Fund	Luke A. Mulligan, M.D.
Medicine and Religion	Jerome G. Kaufman, M.D.
Mental Health	Robert S. Garber, M.D.
Occupational Health, Rehabilitation, Workmen's Compensation	Joseph A. Lepree, M.D.
Publication	George B. Sharbaugh, M.D.
Public Health	John B. Fuhrmann, M.D.
Public Relations	Harry F. Suter, M.D.
Retirement Plan for Physicians	Nicholas E. Marchione, M.D.
Revision of Constitution and Bylaws	Louis F. Albright, M.D.
Traffic Safety	William L. Sprout, M.D.
Woman's Auxiliary Advisory	George O. Rowohlt, M.D.

BICENTENNIAL CONVENTION

Saturday-Wednesday, May 14-18, 1966

Friday, May 13, 1966

Morning — Convention Office and Press Room open, Sun Porch, Lounge floor

5:00 p.m. — Board of Trustees, Bakewell Room

7:00 p.m. — Dinner, Board of Trustees, Derbyshire Room, First floor

Saturday, May 14, 1966

All Day — Installation of exhibits, Exhibit Hall

10:00 a.m. — Registration opens (10:00 a.m.-4:30 p.m.), Stair Hall, Lounge floor

1:30 p.m. — Golden Merit Award Lounge, Rowsley Room, First floor

2:00 p.m. — Golden Merit Award Ceremony, Rutland Room, First floor

2:30 p.m. — Golden Merit Award Reception, Derbyshire Room, First floor

4:00 p.m. — House of Delegates, Vernon Room, Lounge floor, To be followed by (tentatively) MSP Discussion

8:00 p.m. — Nominating Committee, Bakewell Room

(The usual reception and Board dinner on Saturday evening will not be held in 1966)

Sunday, May 15, 1966

Morning — Installation of exhibits, Exhibit Hall

9:30 a.m. — Registration, Exhibit Hall (transferred), (9:30 a.m.-4:30 p.m.)

11:00 a.m. — 9 Reference Committees, Bakewell Room, First floor; Rowsley Room, First floor; Derbyshire Room, First floor; Rutland Room, First floor; West Room, Tower floor; Mandarin Room, Tower floor; Room 1333, Tower floor; Room 1335-37, Tower floor; Room 1344, Tower floor

12:00 noon — Exhibits open, Exhibit Hall (12:00 noon-5:00 p.m.)

2:30 p.m. — House of Delegates (school room setup), Pennsylvania Room

3:30 p.m. — General Session on Medicare, Vernon Room

6:00 p.m. — Reception for President-Elect, Pennsylvania Room

(*) Pennsylvania Room, if can be partitioned

Monday, May 16, 1966

9:00 a.m. — Registration (9:00 a.m.-4:30 p.m.), Exhibit Hall

9:00 a.m. — Exhibits open (9:00 a.m.-5:00 p.m.), Exhibit Hall

9:30 a.m. — 4 Scientific Sessions, Vernon Room, Lounge floor; *Garden Room, Lounge floor; *Rutland Room, Lounge floor; *Solarium, Lounge floor

2:00 p.m. — 4 Scientific Sessions, Vernon Room, Lounge floor; *Garden Room, Lounge floor; *Rutland Room, Lounge floor; *Solarium, Lounge floor

6:00 p.m. — Reception and Buffet Dinner for Technical Exhibitors, Pennsylvania Room

Tuesday, May 17, 1966
BICENTENNIAL DAY

9:00 a.m. — Registration (9:00 a.m.-4:30 p.m.), Exhibit Hall

9:00 a.m. — Exhibits open (9:00 a.m.-5:00 p.m.), Exhibit Hall

9:30 a.m. — Scientific Program, Pennsylvania Room

12:30 p.m. — Luncheon, Vernon Room

2:30 p.m. — Session on History and Medicine, Pennsylvania Room

5:00 p.m. — Exhibits close, Exhibit Hall

5:30 p.m. — Reception by Atlantic City Convention Bureau, Lounge floor (Vernon Room, Garden Room, Solarium and English lounge)

7:00 p.m. — Dinner, Pennsylvania Room

Wednesday, May 18, 1966

9:00 a.m. — Registration (transferred), Stair Hall, Lounge floor (9:00 a.m.-2:00 p.m.)

10:00 a.m. — House of Delegates (school room setup) Pennsylvania Room

1:00 p.m. — Luncheon for delegates, Vernon Room*

2:00 p.m. — House of Delegates (continued, if required), Pennsylvania Room

2:00 p.m. — Registration closes, Stair Hall, Lounge floor

3:00 p.m. — Board of Trustees, Bakewell Room, First floor

3:00 p.m. — Convention Office and Press Room close, Sun Porch

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Neal H. Isil, M.D., R. R. #1, Box 161, Fort Madison, Iowa 52627. University of Istanbul (Turkey) 1955. Board Certified. Available immediately.

ASSISTANT OR ASSOCIATE PATHOLOGIST—C. H. Makris, M.D., 26 Forestdale Avenue, Holyoke, Massachusetts 01041. Athens (Greece) 1952. Board eligible in pathology. Licensed in New Jersey. Available immediately.

CLINICAL PRACTICE—George V. Clift, M.D., 217 William Street, Minoa, New York. Columbia University 1958. Board eligible. Internal Medicine—training endocrinology. Available July 1966.

GENERAL PRACTICE—Edward G. Krug, M.D., 142 Merson Drive, Buchanan, Michigan 49107. Wayne State University 1958. Available immediately.

Warren D. Clift, M.D., 654 Lafayette Avenue, Hawthorne, New Jersey. New York Medical College 1962. Available December 1965.

GENERAL SURGERY — Joseph J. Voytek, M.D., 417 Mechanic Street, Fort Atkinson, Wisconsin. New York Medical College 1949. Board eligible. Available immediately.

GENERAL AND/OR VASCULAR SURGERY—Lester P. Eidelhoch, M.D., 240 Cherry Hill Drive, Bridgeport, Connecticut 06606. New York University College of Medicine 1956. Board Certified. Available immediately.

INTERNAL MEDICINE—Michael A. Bokat, M.D., The Clinical Unit of the Tufts-New England Medical Center, 171 Harrison Avenue, Boston, Massachusetts 02111. Albert Einstein College of Medicine 1961. Board qualified, internal medicine; training in endocrinology. Available immediately.

Leonard Gorkun, M.D., 14 Walnut Parkway, Montclair. Seton Hall 1960. Three-year residency. Available July 1, 1966.

Francis X. McGinn, M.D., 6601 Broadway, Bronx, New York 10471. New York University School of Medicine 1961. Available immediately.

Alfred M. Derrow, M.D., 76A Bowdoin Street, Malden, Massachusetts. Tufts 1962. Available July 1966.

Jerome H. Siegel, M.D., 2441 Webb Avenue, Bronx, New York 10468. Medical College of Georgia 1960. Available July 1966.

Harold J. Kobb, M.D., 6400 Pinefield Road, Columbia, South Carolina 29206. Jefferson Medical College 1960. Available July 1966.

Leroy Strom, M.D., 12403 Stretton Lane, Bowie, Maryland. Available July 1966.

INTERNAL MEDICINE/HEMATOLOGY—David Prager, M.D., 600 Fulton Avenue, Hempstead, New York 11550. Chicago Medical School 1958. Diplomate, Internal Medicine. Available June 1966.

NEUROSURGERY—Mario Ludmer, M.D., 256 Highland Avenue, Pittsburgh, Pa. 15229. University of Buenos Aires School of Medicine 1956. Board eligible. Available immediately.

OBSTETRICS AND GYNECOLOGY—Birute S. Preikstas, M.D., 729 West Corrington Avenue, Peoria, Illinois 61604. Eberhard-Karls University, Tuebingen, Germany 1949. Specialty training in obstetrics and gynecology. Available immediately.

Irwin H. Roseman, M.D., 134 Sachem Road, North Kingstown, Rhode Island. University of New York (downstate) 1959. Completed Part I of American Board. Available July 1966.

Robert E. Lubanski, M.D., 124 Clifton Place, Syracuse, New York 13206. Upstate Medical Center, Syracuse, New York, 1962. Available July 1966.

OPHTHALMOLOGY — Vivian Chen, M.D., 3475 Greystone Avenue, Bronx, New York 10463. New York University School of Medicine 1962. Board eligible. Available June 1966.

PATHOLOGIST—James Ernst Haines, M.D., Worcester Foundation for Experimental Biology, 222 Maple Avenue, Shrewsbury, Massachusetts. Stanford University Medical School 1955. Board certified in Anatomical Pathology. Board eligible in Clinical Pathology. Available October 1966.

PEDIATRICS — Joseph A. Cannaliato, M.D., St. Lukes Hospital Center, 113 Street & Amsterdam Avenue, New York, New York 10025. Seton Hall College of Medicine 1963. Available July 1966.

Roger Kane, M.D., 7430 Pinedale Drive Columbia, South Carolina. University of New York (downstate) 1961. Board qualified. Available July 1966.

PEDIATRIC ALLERGY — Fredric A. Schulaner, M.D., St. Christopher's Hospital for Children, 2600 North Lawrence Street, Philadelphia, Pennsylvania 19133. Tufts 1959. Board certified (Pediatrics). Available September 1966.

SURGERY—David M. Hirsch, Jr., M.D., 2835 Webb Avenue, Bronx, New York 10468. University of Chicago 1959. Board eligible. Available January 1966.

SURGERY AND GENERAL PRACTICE—Ralph N. Lee, M.D., Veterans Administration Hospital, Fort Howard, Maryland. Howard University Medical School 1960. General surgical residency. Available immediately.

BICENTENNALIA

Jonathan Elmer: Medical Progenitor

The Elmer family of New Jersey, through two centuries, has produced a line of medical doctors unsurpassed in number and distinction in the annals of our country. The initial physician of this clan was Dr. Jonathan Elmer, a member of the first medical class to be graduated from the College of Philadelphia (now the University of Pennsylvania) in 1768. Fourteenth president of The Medical Society of New Jersey in 1787, he was followed in this office by Dr. William Elmer (1814-1889) of Bridgeton, elected in 1860, Dr. William Elmer (1840-1908) of Trenton, elected in 1895 and Dr. Henry W. Elmer (1847-1907) of Bridgeton, elected in 1905. The number of other physicians of the family, moreover, is an impressive one. The town of Elmer with its Community Hospital in Cumberland County now bears the name.

Jonathan Elmer, a descendant of John, Bishop of London, in the sixteenth century, was a grandson of Edward Elmer and his wife who emigrated from England to Massachusetts in 1632. His father, The Rev. Daniel Elmer, was minister at Cedarville, N. J., where Jonathan was born on Nov. 29, 1745. The son was one of the first ten men in this country who received the degree of Bachelor of Medicine, after a three-year course, on June 1, 1768. Elmer was a preceptee of Dr. John Morgan, first professor of medicine at the University of Pennsylvania, beginning in 1765. Continuing his studies, upon presentation of a thesis, *De sitis in febribus causis et remediis*, dedicated to Benjamin Franklin, Jonathan Elmer received the degree Doctor of Medicine in 1771—one of the four original M.D. diplomas granted by the University of Pennsylvania.

Returning to his home state, Dr. Elmer became an eminent practitioner. His friend Dr. Benjamin Rush said of him that "in medical erudition he was exceeded by no physician in the United States." In 1772 Elmer was elected to the American Philosophical Society, and in the same year became a member of The Medical Society of New Jersey. As presiding officer of the latter during 1787-88, he read two scientific papers which were later published in the Society's *Transactions*.

Turning to politics at the outbreak of the Revolution, Dr. Elmer had an equally distinguished public career. A delegate to the Continental Congress for five years, he was inspector of military hospitals during the War. Reading law after medicine, he was Surrogate of Cumberland County from 1784 to 1802, and a Judge in the County Courts until 1814. A member of the New Jersey Legislature in 1780 and 1784, Elmer subsequently served in the U. S. Senate from 1789 to 1791. He was a trustee of Princeton College from 1782 to 1795. He died on Sept. 3, 1817, and was buried in the Presbyterian Churchyard at Bridgeton. His unpublished writings on medical and legal, philosophical and literary matters are now owned by the widow of the late Dr. Robert P. Elmer, a general practitioner in Wayne, Pennsylvania.

Drs. Walter G. (Emeritus Professor of Orthopedics at the time of his death in 1960) and Robert P. Elmer, sons of Dr. William Elmer of Trenton, represented the fifth generation of the family to hold medical degrees from the University of Pennsylvania. It is to be anticipated that future generations of the Elmer tribe will continue these illustrious examples of service to medicine and to the nation.

Fred B. Rogers, M.D.

BICENTENNIAL CELEBRATION
May 14-16, 1966
Haddon Hall, Atlantic City

The Passaic County Medical Society In The Nineteenth Century*

There was no practicing doctor in the Passaic area for more than half a century after the first settlement. The first physician was Jacob Arents, who came from Germany in 1707, settling at Perth Amboy, when he removed to Delawanna. Dr. John De Vausnee settled there in 1738. He had a general practice over a large territory, where he was known as "the French doctor." The following receipt in the doctor's handwriting reads in translation:

Received from Michael Enoch Vreeland, the sum of sixteen shillings, the amount of my demand of this day, the 13th of June, 1959.

Dr. De Vausnee died in 1760, being succeeded by Dr. Abiatha Millard, who purchased his old home and continued a general practice of medicine for six years and then removed to Newark, because no doctor was needed in Aquackanonk.†

Dr. Thomas Steel of Belleville was well and favorably known about this period. Dr. Cora Osborn practiced from 1814 to 1819. The most famous physician of those days was Dr. Benjamin R. Scudder, who came to Aquackanonk† in 1769 practicing until his death in 1819.

In 1820, Dr. Lambert Sythoff settled in Aquackanonk. In addition to his duties as a physician he conducted a private classical school.

Dr. Garret Terhune succeeded Dr. Pratt in 1827, continuing in practice until his death in 1885. The doctors were either skilled fellows or the inhabitants were a hardy lot between the years 1737 and 1795, when the average number of deaths per year was less than two, judging from the tombstones in the old church yard. During the next thirty-six years, the average was only six. The year 1829 was a harvest for the undertaker-sexton, who had nineteen funerals.

About 1810, Dr. William Ellison practiced in Paterson. He had a small home where the First Baptist Church now stands. Ellison Street is named after him. He was president of the Essex County Medical Society. Passaic County was part of Essex County until 1837.

A contemporary of his was Dr. Ebenezer Blackley. He had been in the Revolutionary War, endured the hardships of that famous winter at Valley Forge, and had also fought at the Battle of Monmouth.

In 1828, at a meeting of the Essex County Medical Society, the following Paterson physicians were present: Lemuel Burr, William Ellison, Sam Mead, James Warren, Elias J. Marsh 1, and William McCoppen.

1829. The census of Paterson gave nine physicians, one grocery and drug store, and one medicine and drug store.

1832. In June a patient published in the Paterson Courier a denial of reports that he had been charged an exorbitant bill by Dr. L. Burr; that he hadn't received any bill as yet; and that he had full confidence in Dr. Burr, and stood ready to pay whatever bill Dr. Burr saw fit to render.

1837. Paterson became the county seat of the newly formed County of Passaic. That year only six regular physicians were in active practice in Paterson: Dr. Elias J. Marsh I; Dr. William Magee; Dr. Donation Binsse; Dr. Hoxsey; Dr. Lemuel Burr, and Dr. Alexander W. Rogers. Dr. Garret Terhune was at Aquackanonk and Dr. J. R. Riggs was in Newfoundland.

1842. A. Mr. Hays published in a newspaper a letter of gratitude, thanking Dr. J. Magee for a successful operation on his eye. The operation was for strabismus, commonly known as "squint." There was no pain and

* Assembled by Irving R. Hayman, M.D.
† Old name for Passaic.

there was also sight. This was one of the first strabismus operations performed in this state.

On November 14, 1843, at the State Medical Society meeting at Princeton, an application was made for authority to organize a district Medical Society in the County of Passaic. This application was signed by Garret Terhune, Elias J. Marsh I, Donation Binsse, L. Burr, and Jeter R. Riggs. The application was acted on favorably. On January 16, 1844, the commissioners met at the Franklin House. Dr. G. Terhune was elected president; Dr. J. R. Riggs, vice president; Dr. L. Burr, secretary; and Dr. William Magee was elected a member and also treasurer.

On April 1, 1844, the Society met at the Court House. The President, Dr. Terhune, delivered an address on hernia and Dr. Magee filed a certificate of the intention of Robert J. Whitely to study medicine under his care. In October 1844, a Board of Censors was organized to examine candidates and recommend them (if found competent) to the president of the State Society for its diploma. In April 1845, the Censors examined Dr. Alexander W. Rogers and he was accepted. In October 1845, the Bylaws were adopted. Several items in this set of Bylaws are of interest: first, the members were to regulate their charges by the list of the State Society; second, any dispute between members would be referred to the Society for settlement; third, all members were to conduct themselves with decorum and courtesy, one to another.

1847. Dr. Marsh of Paterson and Dr. L. A. Smith of Newark were the New Jersey delegates sent to aid in the organization of the American Medical Association at Philadelphia.

1849. Drs. Marsh and Rogers were appointed as delegates to the American Medical Association convention held in Boston. Dr. Marsh read a paper on the "Curative Effects of Cold Water."

1852. It was resolved that the ordinary charge for a visit should be 50¢ and for an "ordinary" obstetric case, $5.00.

1862. The fee for an ordinary visit was raised to 75¢, with 50¢ a mile charge for every mile over the first mile. Two years later, fees were $1.00 for an ordinary visit and $10.00 for an obstetric case. In 1865, the dues of the Society were raised to $2. This jumped to $5 in 1866. In 1870, Dr. Elias J. Marsh II became a member.

1879. Dr. Philander A. Harris and Dr. J. B. Wright were admitted as members. It was in 1879 that monthly evening meetings of the Society were started. Two years prior, there had been formed a Paterson Medical Association, to which many of the physicians belonged and which met monthly. After the Society monthly meetings, the Paterson Medical Association disbanded.

1885. The question of preliminary education for medical students was vigorously discussed. It was felt that a man to enter medical school should at least be prepared to enter *any* freshman class in *any* college. And in this year also was started a movement for a library of our own. Rooms in the First National Bank Building were rented for a meeting place and library.

1890. Dues were raised to $7.00.

1894. This year marked the 50th Birthday of our Society. At the April meeting, Dr. Alexander W. Rogers delivered an historical address which was most complete and interesting.

1899. It was debated whether improvement in the number of cases of diphtheria was due to early use of antitoxin or to a less virulent infection. School hygiene came to fore. Reports of good results with x-ray film were made and it was stated that "No doubt in the future every hospital must have an x-ray apparatus."

Dr. Joseph Williams had the first x-ray machine in Paterson. It was burned in the Big Fire. For several years after this, there was not a single x-ray machine in Passaic County.

1901. The "usual" typhoid epidemic was much milder this year. Diphtheria was more severe, but antitoxin was winning friends. Smallpox was prevalent and rather mild this year. Vaccine had its proponents and opponents. Spinal anesthesia had been used with no bad results reported. X-rays for fractures, dislocations, and foreign bodies were considered satisfactory. No good results had as yet been obtained in diagnosing renal calculi by means of x-ray.

1908. Dr. Elias J. Marsh II died this year. Dr. Marsh was born in Paterson in 1835. He received his A.B. from Columbia in 1854, his M.D. from College of Physicians and Surgeons in 1858. He entered the Union Army in 1861. After the battle of Gaines Mill in 1862, being in charge of a field hospital which was left behind in the Federal retreat and remaining with the wounded, he was captured by the Confederates. In a few weeks he was exchanged. He then had charge of the Judiciary Square Hospital in Washington, D.C. Afterwards, he was with Gregg's Division Cavalry Corps. During 1866 and 1867, he was surgeon at West Point. Dr. Marsh began the practice of medicine in Paterson in 1870. In 1874, he became medical director of the Mutual Life Insurance Company in New York. He was appointed first president of the New Jersey Board of Health in 1877. He was elected president of our County Society in 1881; and in 1885, he was appointed surgeon at the Paterson General Hospital. At the Paterson Exposition in 1900, he was awarded a gold medal for his work on mortality statistics. He died in 1908, the second of a direct line of three eminent physicians of the same name. He left his son, Dr. Elias J. Marsh III, who still carries on this fine family tradition.

1912. Dr. David D. Bowden died this year. He was the first orthopedic surgeon in town and founded the orthopedic service in the Paterson General Hospital. Dr. Michael W. Gillson died this year also.

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal is the official organ of The Medical Society of New Jersey, published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey, 08605.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

Contributions: Manuscripts submitted to *The Journal* must be typewritten, double-spaced on letter size (about 8¼ by 11 inch) paper, and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not; and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit original copies only, and are urged to keep carbon copies for reference. It is understood that material is submitted here for exclusive publication in this *Journal*.

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original sketches, from which cuts or plates will be made by *The Journal*. The cost of making such cuts will be borne by the author, who will, after publication, receive the cuts for his own use. The cost of these cuts varies with the size and type of the illustration.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton, New Jersey 08605

BOOK REVIEWS

The Emerging Adventure in World Health. By Leona Baumgartner, M.D., New York, 1963, American Public Health Association. Pp. 42.

The long-range planning role the United States is playing in developing countries is frequently obscured; perhaps never more so than at present in Vietnam. Our long-range planning recognizes vital health needs as imperative if economic progress is to be made in these countries. This is attested to by Dr. Baumgartner's exposition of the responsibility of the Agency for International Development. She traces the history of the United States in alleviating medical needs abroad, both through private and voluntary organizations, by missionaries and by business organizations as well. These efforts used to be transitory and unrelated. The Agency for International Development (the service to which Dr. Baumgartner progressed following her years as Commissioner of Health in New York City) is now the key agency for health services abroad. It is the coordinating force for all the other United States health activities overseas (these include Public Health Service, Peace Corps, United States Army, semiofficial agencies and affiliations with World Health Organization).

Dr. Baumgartner discusses with great understanding the problem of "giving" aid, with the obstacles presented by cultural blocks and local customs which make blank acceptance of scientific advances impossible. This is a problem which, incidentally, carries over to our own shores when we try to reach the so-called "hard-core" groups whose exposure to health education has not effected the acceptance we anticipated. Our missionary zeal to transpalnt an entire medical technology to these soils and expect the program to "take" successfully must be modulated by a full understanding of the culture with which we are working.

SHIRLEY A. MAYER, M.D., M.P.H.

Ciba Foundation Study Group No. 18, Brain Thyroid Relationships. Edited by Margaret P. Cameron, M.A. and Maeve O'Connor, B.A. Boston, 1964, Little, Brown and Company. Pp. 117. ($1.95)

This small volume is packed with the ingenuity and fine thought necessary to disclose the relationships in a very complex feedback system. All the components are not clearly delineated as yet, but many promising leads are given. The list of contributors has an international flavor.

G. W. Harris of Oxford discusses hypothalamic control of TSH secretion, the feedback action of thyroid hormone, and the presence and probable action of thyroxin and TSH in the hypothalamus and neurohypophysis. The relationship of vasopressin and thyroid function was studied in rats and rabbits. The neurohumeral control of TSH and a TSH releasing factor are shown in experiments under the electron microscope. Substances on the hypothalamic nerve endings were shown to be released into a portal venous system.

The latter discussion typifies the tenor of other dissertations. One particularly ingenious experiment described by Bengt Anderson of Stockholm shows that pituitary transplants to the eye of a goat no longer respond to TSH stimulation, presumably because of neural severance from the hypothalamus.

This is not a book for general medical reading and is meant for the specialist interested in the endocrine field. However, by its excellent critical discussions, orderly arrangement, and suggestions for further confirmatory experiments, it serves as an excellent example of the free roving imagination systematically contained.

EVERETT O. BAUMAN, M.D.

Body Fluids and the Acid-Base Balance. By Halvor N. Christensen, Ph.D. Philadelphia, 1964, W. B. Saunders Company. Pp. 506, illustrated. ($6.50)

Here is a self-instructional, programmed course on the major aspects of electrolyte balance in health and disease. It stresses fundamental concepts through brief discussions with questions and answers so arranged that the reader may evaluate each fact before proceeding to the next item. The subject material is arranged as follows: pH and Dissociation (263 items), sodium and chloride Distribution (137 items), potassium and cellular compartments (134 items), calcium and phosphorous (129 items), gas transport (189 items), metabolic and respiratory aspects of neutrality regulation (160 items), and renal correction of the neutrality (124 items).

The course is an excellent review for students who have previously studied the subject. For one unacquainted with the material, some study of standard text books of biochemistry and physiology would be desirable before attempting the programmed course. In either instance, the value of the book lies in the manner in which it is used. Casual reading or examination is of little benefit. By a conscientious completion of each item in sequence, the student may obtain knowledge of the fundamentals of acid-base balance and its physiologic regulation.

R. L. GARNER, PH. D.

Animals Parasitic in Man. By Geoffrey Lapage. New York, 1965, Dover Publications, Inc. Pp. 320. ($1.85)

This is a valuable and handy reference source for students, physicians, biologists, and for laymen interested in parasitology. The material is presented in an interesting relaxed manner peculiar to fiction, thereby avoiding the dry verbiage of the scientific text.

Dr. Lapage gives an interesting account of the more important parasites that affect man both directly and indirectly. These parasites produce diseases in man and destroy animals which man depends upon for food stuff. Host-parasite relationships have been selected from most of the phyla of the animal kingdom. The ecology of parasitism is well covered. The author includes a vivid description of the life histories of the host parasite relationship. Life histories of the hookworm, roundworm, threadworm, flukes, tapeworms, material parasites, trypansomes, leeches, ticks, lice, and mites are fully covered.

Each life history includes portal of entry, reproductive systems, host parasite relationship, and geographic distribution throughout the world.

The many line illustrations add to the valne of the text.

FRANK WERTYLYK, B.S.

Christopher's Textbook of Surgery. Edited by Loyal Davis, M.D. Ed. 8. Philadelphia, 1964, Saunder. Pp. 1481, with 1341 illustrations. ($18.50)

Completely revised since the 1960 edition, this is a "must" for all medical students, undergraduate and graduate, and busy practitioners. The text opens with a well written chapter on the history of surgery from pre-historic times to the present. Progressively, the reader advances from the basic concepts, the discussion and treatment of wounds, burns, shock, anesthesia, and post-operative care, to the chapters dealing with the diseases of the various organs and systems of the body. Each of the 33 chapters is by an outstanding specialist; each deals with a specific organ or system, and presents in a clear and concise manner, a discussion of the diseases affecting that system. Each chapter reviews its subject from an anatomic, physiologic, pathologic, symptomatic, and diagnostic standpoint. Treatment covers the medical as well as the surgical approach. Surgical technics are well outlined and well illustrated. The last three chapters, dealing with the qualifications of a surgeon, surgical judgment, and "Horizons in Surgery," are of particular interest to the aspiring surgeon. The chapter on Physical Medicine and Rehabilitation is of particular note.

A. L. Hoffman, M.D.

The Retinal Vessels. R. Seitz, M.D. Translated from the German by F. C. Blodi, M.D. St. Louis, 1964, Mosby. Pp. 186 with 363 illustrations, including 32 in color ($14.50)

This small book represents a great deal of reading plus clinical and laboratory research on the comparative study of ophthalmoscopic appearance and histologic findings in the retinal vessels in many disorders. The author was able to study histologically a hundred eyes which had been examined ophthalmoscopically while the patients were alive.

This enabled the author to clarify our basic knowledge regarding "crossing phenomena" better known in this country as "A-V nicking." The text illustrates the signs manifested in the retinal vessels in many circulatory disturbances.

The monograph is a remarkable example for a dissertation to achieve higher academic qualification. The student, teacher, and scientist will see this book as an interesting basic source of information. The busy practitioner will find it stimulating, illustrative and conclusive.

The translation is good, easy English. The printing and illustrations are excellent.

Bela Szinfgh, M.D.

Cerebral Palsy. By Sidney Keats, M.D. Illinois, 1965, Charles C. Thomas, Publisher. Pp. 369. ($12.50)

This scholarly review of the historical background, pathogenesis, classification, and treatment of cerebral palsy, will be of help to all persons working with the cerebral palsied. It is a good textbook for medical students and practitioners.

The author's emphasis on the multifaceted problem of cerebral palsy with the need for the team approach is well documented. The section on drug therapy is not as complete as the other chapters, but this is understandable as that topic would fill a book in itself.

Catherine E. Spears, M.D.

With Every Breath You Take. Howard R. Lewis, Public Health Consultant. New York, 1965, Crown Publishers. Pp. 322 ($5.00)

Few subjects could be of more universal interest than the air we breathe. The air pollution problem critically concerns New Jersey residents, especially our physicians. Our state enjoys a saturated concentration of the two major causes of this ever growing problem: industry and the motor vehicle. In this fascinating book with the minimum of jargon, Mr. Lewis explains the causes, effects, and prevention of air pollution. Photographs show the murky sky line of New York and other cities blanketed by a poll of pollution. If you want to do further reading on the subject (and you should), there is an excellent bibliography.

We have taken great strides in other fields of preventive medicine, but now are only beginning to grapple with the serious hazard of air pollution. The air is a sewer, and we have no choice but to breath it. It is high time we paid some attention to the garbage we spew into it. Howard Lewis tells you what we can do.

Phone your book store at once. Read the book. You will be shocked, alerted, and informed about one of the greatest dangers of modern civilization.

Frank L. Rosen, M.D.

Fracture Problems. W. H. Harris, M.D., W. N. Jones, M.D. and O. E. Aufranc, M.D. St. Louis, 1965, Mosby. Pp. 371 with 199 illustrations. ($20.00)

Doctors Harris, Jones, and Aufranc have collected a choice series of problem fractures. For the orthopedist with wide fracture experience, the presentations will recall similar problems and complicating incidents; for the physician treating the occasional fracture, the book will give much food for thought; and for the orthopedic resident and young practitioner, there is a world of material.

The method of presentation is alive and interesting. Actual cases are discussed, starting with the pertinent history and findings together with necessary laboratory and x-ray information. Proposals as to how to treat the patient are discussed in a round table manner. For each case, method of treatment is well described, problems and complications freely explained, and reasons for the method chosen are fully discussed.

The panel includes such seasoned orthopedists and "fracture men" as Harris, Jones, Aufranc, Cave, Record, Rowe, and many more. When one can tap the experiences of so many experts, the wisdom they can offer is well worth the purchase price of this book.

Harold T. Hansen, M.D.

Physiologic Foundations for Marriage Counseling. Joseph B. Trainer, M.D. St. Louis, 1965, Mosby. Pp. 285. ($8.00)

In an ambitious attempt "to include all the major problems people may have to deal with in the course of marriage," Dr. Trainer has, in this compact volume, furnished chapters on the anatomy and physiology of the genitalia, the social meanings of marriage, the psychology of mate selection, methods of counselling, and "re-energizing the de-energized" adult. The book is written with both wit and wisdom, and there are many nuggets of hard-nose, practical advice imbedded in a network of sound, if somewhat abstract, generalizations. It is an unusual combination of a philosophy of marriage counselling and a how-to-do-it handbook. (The "how to do it" refers to counselling methods not sexual technics.)

Victor Huberman, M.D.

Preventive Medicine. Edited by Herman E. Hilleboe, M.D. and Granville W. Larimore, M.D. Second Edition. Philadelphia, 1965, W. B. Saunders Company. Pp. 523, illustrated. ($12.00)

That 50% of the practice of medicine is or should be devoted to the prevention of disease and the prevention of disability or progression of disease is emphasized in this excellent textbook designed for medical students and practicing physicians. The authors, most of whom have been staff members of the New York State Health Department, are experienced teachers and health officials who have dealt with the day-to-day problems relating to patients, physicians, and community health agencies. Teachers of preventive medicine might have preferred a more detailed discussion of the "basic sciences" of preventive medicine; i.e., biostatistics and epidemiology; however, what is presented is concise and informative, and the references throughout the text are first rate. Chapters devoted to subjects such as air pollution, narcotic addiction, evaluation of screening methods for early detection of disease, and social work provide sound introductory information for all students of medicine, whether they are at the pre- or post-doctoral level. Those readers who wish to learn more about specific subjects will find the source material to get them started, and others who limit their search for knowledge to the textbook material will at the least find they can now speak intelligently as informed health scientists. The breadth of topics covered and the clear-cut presentations by the authors remind this reviewer of the vast amount of preventive measures that are available and could be applied by a knowledgeable profession willing to act. In 1952, Dr. Alan Gregg of the Rockefeller Foundation, speaking to teachers of preventine medicine (and, in the Hippocratic sense, to all of us) said: "Preventive medicine has the charm and bewilderment and the opportunity of being virtuous, because applying preventive medicine is behaving as we should behave in the light of what we know of the vast capacities of medical science."

THOMAS M. GOCKE, M.D.

Tracy's: "The Doctor as a Witness." Ed. 2. William J. Curran, LL.M. Philadelphia, Saunders, 1965. Pp. 197.

In 1957, Professor Tracy published a short, witty, and practical guidebook for physicians called on to testify. This new edition brings many of the citations up to date and completely revises the vital material on malpractice. A new chapter reviews the legal aspects of clinical experimentation. Professor Curran, who heads up Boston's unique Law-Medicines Intitute, was a happy choice, since he brings to this work an unusually rich background in medical jurisprudence and forensic medicine. Here he practically takes the doctor by the hand and leads him step by step through the preparation for and testimony at the trial. He covers disability evaluation, the philosophy of our adversary system, use of medical records in court, the doctor's physical appearance in the court room, the hypothetical question, fees, and even how to be happy while being cross examined. The latter alone is worth the price of admission. Many texts on the doctor as a witness are silted with pious generalities, little sermons on truth and dignity, and vague abstractions. But this second edition, like its distinguished predecessor, is practical, concise, and eminently useful. The experienced medical witness will find here some ideas that, with all his experience, he had not thought of. And the inexperienced physician-witness will find that this volume will go far towards taking the voodoo out of going to court.

HENRY A. DAVIDSON, M.D.

Textbook of Obstetrics. J. C. Ullery, M.D., Z. J. Hollenbeck, M.D. and 31 other contributors. St. Louis, 1965, Mosby. Pp. 752 with 292 figures, 3 color plates and 26 tables. ($17.50)

The Department of Obstetrics of Ohio State University has here assembled a thoroughly up-to-date, patient-care oriented volume covering the management of the pregnant woman and the handling of complications of pregnancy and the puerporium. The book is targetted at both medical students and post-doctoral residents and fellows. There is a brief (40-page) monograph on the pituitary-ovary-endometrium cycle. Apart from this, the text is essentially a practical one, covering not only the conduct of labor, but also such often-neglected items as gastro-intestinal problems in pregnancy, the role of hypnosis (the author is "not favorably impressed"), family planning, obstetrical shock, managing the postmature infant, and "natural childbirth." (The contributor's attitude here is skeptical.) The commoner obstetrical problems are reviewed in sound and usable fashion. Most of the contributors state their positions and preferences clearly and unequivocally so that no reader is left in doubt as to the author's favorite methods. This modern volume can be an enormous help to the obstetrical resident or beginning practitioner; and it won't hurt an experienced obstetrician, either, to sample the recommendations and experiences of the distinguished group of contributors.

ULYSSES FRANK, M.D.

Simple Splinting. Jerome Rotstein, M.D. Philadelphia, 1965, Saunders. Pp. 126. Illus. 285. ($6.50)

Here is a useful guide to a general practitioner interested in rheumatoid arthritis. Although half of the pages are used to illustrate splinting, this is the weakest section of the book. The chapters dealing with the history of the treatment of arthritis, the conservative therapeutic regimen, and the pharmacologic treatment of rheumatoid arthritis are the most impressive sections here.

The section dealing with the anatomy and classification of the joints would disturb any anatomist. Too many basic errors can be noted. The articulation of the elbow on page 35 and the knee on page 38 are glaring examples of this. Is not the terminal rotation of the knee joint due to the difference in size of the femoral condyles, rather than to muscle pull? The description of the nucleus pulposus as a fibro-cartilagenous material rather than a mucoid substance would lessen the mobility of the spine.

The chapter from which the book derives its title seems to deny its appellation. The preparation of some of the splints is not simple, nor do they appear to be comfortable to the patient. A plastic appliance made from a positive plaster model and then lined with rubber and hung from the neck by a single band of webbing appears cumbersome. The recommended "Back Splint" requires considerable time to construct, and does not appear to provide the immobility or comfort that a well fitted, well constructed garment might furnish. These splints would be difficult for a general practitioner to make. The rheumatologist would find their construction too time-consuming. It would probably be some occupational therapist who could find the time, patience, and energy to build the suggested appliances.

"The Pharmacologic Treatment of Rheumatoid Arthritis," however, attests to the author's knowledge of the treatment of rheumatoid arthritis.

CHARLES I. NADEL, M.D.

Today's Health Guide. Edited by W. W. Bauer, M.D. Chicago, 1965, American Medical Association. Pp. 624. ($5.95)

What is this new *Today's Health Guide?* What is it attempting to do? The AMA has produced a very clear, readable, and attractive resource book from many unpaid contributors. It would assist the "homemaker" in approaching the whole field of health in what we physicians presently consider the correct manner. The introduction states that this is *not* a "doctor" book nor a medical encyclopedia. It seems to be a general guide to the theory and practice of good health, with a good introductory picture of the health world, from birth through maturity onto aging, with some information on sickness and disease and how to deal with these malfunctions both individually and at a community level.

In its 624 pages, the Guide is frequently quite lacking in specific detail. It is too much so to allow one to say that this should be the family's only medical guide book. As an example, I wanted to tell a patient about the significance of his newly found hydrocele. Why not try the new book I had been playing up so? A look in the index. No mention of hydrocele. And hernia? Yes, but the text show hernia mentioned only under "quackery" from the standpoint of trusses and nonsurgical cures. Comparative shopping in the local library showed me last year's product of the well-known how-to-do-it organization, Better Homes & Gardens. Their *Family Medical Guide* not only had material, with illustrations, about both subjects, but went into detail about their repair. My conclusion: both books are needed to give a complete family reference setup for medical guidance.

The AMA book covers more on community health resources and the economics of medical care, has more on the physician's attitude and methods, and it includes a few unnecessary sections such as 'Questions and Answers' and an insufficient glossary. This book should be looked over by all those in or interested in the field of medicine. I recommend it for the library of every intelligent family, and for every physician's waiting room. But, alone, it is not enough to call it anywhere near a complete guide or manual.

JOHN WINSLOW, M.D.

Trauma to the Liver. By Gordon F. Madding, M.D. and Paul A. Kennedy, M.D. Philadelphia, 1965, Saunders. Pp. 134, illustrated. ($6.00)

Liver trauma represents a major problem among battle casualties, and it is a frequent occurrence in traffic accidents. The authors of this monograph have recorded their opinions and selected concepts from the literature on surgical management of liver trauma. Detailed accounts are provided of surgical anatomy of the liver; and diagnosis, surgical treatment, and complications of liver trauma. The importance of effecting hemostasis, securing adequate drainage, decompressing the biliary tract, avoiding packs except as a temporary expedient, use of resectional debridement, and use of hypothermia are appropriately emphasized. The book is well illustrated and has an adequate bibliography for the areas covered.

This book, intended for the practicing surgeon, would be of greater value if it had included an integrated approach to management of common types of liver trauma. Thus, it would be desirable to review the management of complications of trauma resulting from percutaneous cholangiography and needle biopsy of the liver. Another major deficiency is failure to provide a basis for advocated therapy. Little of the recently available information is included on hepatic regeneration, the role of the liver in coagulation, metabolism of antibiotics in the normal and diseased liver, and the effect of anesthesia, shock, and hypothermia on hepatic function and structure. The preoperative and postoperative evaluation of hepatic function is not included, and information on supportive medical measures is inadequate. This is reflected in the suggestion that parenteral vitamin K may be useful to correct hypoprothrombinemia incident to widespread hepatocellular damage.

Despite these defects (which may be corrected in subsequent editions), this book provides an easily readable account of the surgical approach to liver trauma which should be helpful to the general surgeon.

CARROLL M. LEEVY, M.D.

Rheumatic Fever: Diagnosis, Management, and Prevention. M. Markowitz, M.D. and A. G. Kuttner, Ph.D., M.D. Philadelphia, 1965, W. B. Saunders Company. pp. 242. ($7.50)

At last we have a comprehensive, unbiased, up-to-date review of a subject about which experts have disagreed in the past decade. Each contributor here is an expert in rheumatic fever; and each adds to the other's knowledge of the bacteriology and clinical aspects of the disease. In addition, a chapter on "Community Health Services" by Leon Gordis, M.D., is included. The writing is clear, concise, and easily grasped with one reading. The print is "easy-on-the-eyes."

The biology of group A beta hemolytic streptococcus and its components is desribed, and its relationship to the etiology and pathogenesis of rheumatic fever is emphasized. Chapters on clinical manifestations of acute rheumatic fever, laboratory findings, radiographic and electrocardiographic findings, and differential diagnosis are included, and the pratical aspects are emphasized for use by the practicing physician.

In addition to describing the clinical course and prognosis of acute rheumatic fever, the authors also described rheumatic fever recurrences and chronic rheumatic heart disease with its management and complications.

Four appendices are included, three of these summarizing (almost in table fashion) a great deal of what is written in previous chapters. These appendices serve as a quick source of information after one has carefully read the book in its entirety. Appendix 1 guides one in the diagnosis of rheumatic fever; appendix 2, in prevention of rheumatic fever; and appendix 3, in prevention of bacterial endocarditis. Appendix 4 describes a method for culturing beta hemolytic streptococcus from the throat and clinical interpretation of laboratory reports. For physicians treating many respiratory illnesses, this method will be helpful in recognizing and differentiating streptococci (alpha, beta, and gamma), pneumococci, staphylococci, and other pathogenic organisms, so that a more scientific approach may be used in the physician's office before administering antibiotics without reason. In addition, antibiotic sensitivity discs may also be applied to the culture media to help one choose the proper drug.

I recommend this monograph to pediatricians, internists, and general practitioners who take care of rheumatic fever patients.

MILTON PRYSTOWSKY, M.D.

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ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

December, 1965 VOL. XXXVIII, NO. 10

Evidence is presented that reactivation of a previous infection is a plausible explanation of the pathogenesis of chronic pulmonary tuberculosis even when it appears for the first time in an older person. No evidence was found to suggest exogenous reinfection in such a person.

PULMONARY TUBERCULOSIS AMONG OLDER PERSONS

An important factor in the continuing existence of tuberculosis in the population is the older person with active pulmonary tuberculosis. Some cases among older people are reactivations of previously known tuberculosis, but often there is no history of such a previous episode.

It is important to recognize active tuberculosis in older persons because such persons may endanger children, or, if in a nursing home, may be cared for by young adults who are tuberculin negative.

In the present study, an attempt has been made to gather two types of information: (1) the frequency with which a recent close contact with an open case of tuberculosis could be found as a source of infection in persons with primary tuberculosis, whether child or adult, compared with finding the source contact in older persons with active chronic pulmonary tuberculosis of recent onset; (2) the frequency with which evidence could be found of the previous existence of tuberculosis in the older person as revealed by roentgenograms made at least a year before hospital admission.

Frequency of recent close contact with open tuberculosis was elicited in three groups of patients:

Older adult patients. In 102 cases of active pulmonary tuberculosis in persons 50 years of age or older, only 5 patients had a significant contact with an open case within the past several years.

Children with predominantly primary tuberculosis. In a group of 136 children admitted to the sanatorium, significant close exposure to a case of contagious tuberculosis was found to have occurred within the previous year in 112 (82 per cent).

Adults with primary tuberculosis. The cases of 30 young adults (aged 17 to 30) with primary tuberculosis were reviewed. This was to combine the factor of being adult with the factor of primary infection in order to eliminate the possibility of endogenous reinfection as the mechanism.

Tuberculosis was deemed to be primary if the date of conversion of the tuberculin skin test was known to be recent or if the lesion was strictly limited to a portion of the lung commonly affected by primary tuberculosis. Close contact with an open case of tuberculosis within the previous year was established for 20 (67 per cent) of the 30 adults.

Statistical analysis of these data revealed no significant difference in incidence of source cases for primary infection between children and adults. A high degree of significance could be attached to the much lower incidence of recent re-exposure among the older adults.

The time-honored explanation that an adult has contact with so many persons as to make it extremely difficult to locate the one responsible for the "reinfection" appears to be untenable. When endogenous reactivation was eliminated from consideration in the adult

William Stead, M.D. *The American Review of Respiratory Diseases,* June, 1965.

patient, the source of infection was established in a high proportion of cases.

Reinfection Unlikely

The unlikelihood of reinfection in the majority of these cases suggested that reactivation of old disease might account for more of the cases of newly discovered active tuberculosis among older adults than is generally thought.

To evaluate this possibility, the records of 445 patients admitted to the sanatorium during a 12-month period were studied. Among 102 patients 50 years of age or older who had chronic pulmonary tuberculosis, 12 cases were reactivations of known adult lesions which had been treated from 7 to 50 years previously.

In the remaining 90 patients, no history of previous tuberculosis could be elicited. In only 5 of these was there a recent exposure to open tuberculosis. Roentgenographic evidence of antecedent disease had been present for at least one year in 51.

The observations reported offer nothing in support of exogenous reinfection and provide evidence that unrecognized latent tuberculosis is often present for years before the development of the first clinical episode of the disease in persons more than 50 years of age.

In primary tuberculosis for which an exogenous source of bacilli is necessary, it was possible to identify the source of bacilli in the majority of cases in adults as well as in children. Thus the reason for the difficulty in identifying sources of "reinfection" appears to be that re-exposure is not related to the development of active tuberculosis in a person who has been infected in the past. Casual contacts are unlikely to cause primary infection, much less reinfection.

Reactivation of dormant foci of previously unrecognized tuberculosis seems even more plausible as an explanation for tuberculosis in the older adult when considered with the fact that roentgenographic evidence of pre-existing tuberculosis was found in 72 per cent of older persons experiencing their *first* clinical episode of the disease.

In a large number of these persons, there was evidence of pre-existing scars on the lung from which reactivation might have occurred (often referred to as Simon foci).

Significant Scars

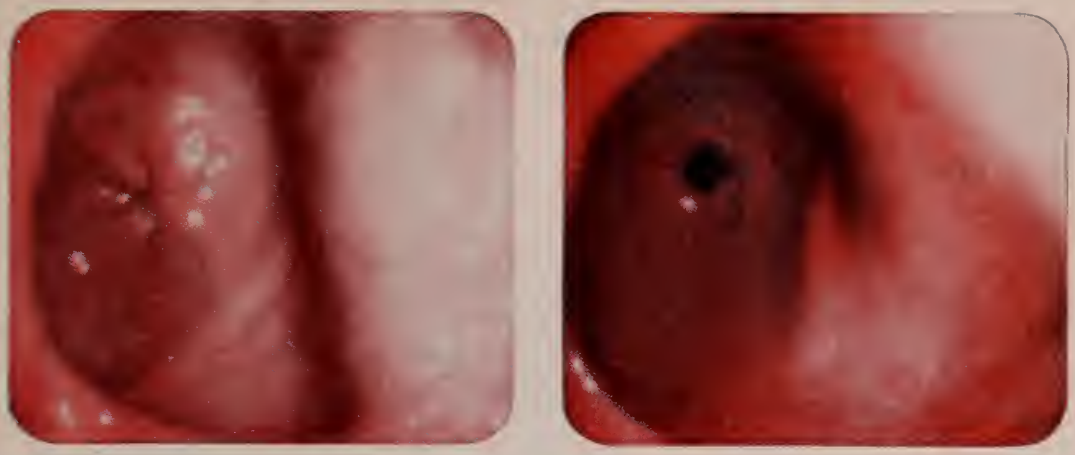
The origin of such scars has been the subject of debate for many years. Many have considered such scars abortive episodes of post-primary tuberculous foci which should not be considered abnormal. However, the observations in this study suggest that even though they remain unchanged for years, they should be regarded as potential sources for reactivation of tuberculosis during subsequent periods of stress, hormonal changes, and advanced years.

Factors frequently related to reactivation have been old age, alcoholism, cortisone therapy, diabetes, silicosis, major gastric resectional surgery, and chronic illness due to a low-grade malignancy.

As improved and more refined techniques are sought for the control of tuberculosis in the community, more attention should be focused upon tuberculin reactors whose roentgenograms reveal scars, whether there is a history of tuberculosis or not. While a reactivation of tuberculosis occurs in only a small portion of such persons in a given year, each reactivation may delay eradication of tuberculosis by planting bacilli in a new victim.

Infection of tuberculin-negative contacts can only be prevented by detection and treatment of reactivations before liquefaction necrosis develops with dissemination of organisms into the environment.

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1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

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A savings account in the Orange Savings Bank is one of the safest non-fluctuating investments a person can make.

The current interest rate on savngs is 4%—payable and compounded quarterly. Payable from the first day of deposit. (There is no waiting period!)

We have a record of uninterrupted dividend payments over the past 111 years.

For your convenience, transactions may be handled by mail.

Stop to consider it—saving here is your best non-fluctuating investment!

Save at the Oldest Mutual Savings Bank in Essex County
ORANGE SAVINGS BANK
MAIN OFFICE AT MAIN AND OAY STREETS
DRIVE-IN OFFICE AT SO. ESSEX AVE. AND HENRY ST.
MEMBER FEDERAL DEPOSIT INSURANCE CORPORATION

1966-67 Membership Directory

It is now time to begin the initial work of the preparation of the 1966-67 **Membership Directory.** As a first step, within the next month or two each member will receive an informational data sheet. All members listed in the 1964-65 directory will be supplied with exact copies of their current directory listings and will be asked to verify or modify those listings, as the case may be. Members to be listed in the directory for the first time in 1966-67 will be asked to supply the full data requested.

Your cooperation is earnestly solicited. Accurate and complete data from you will help us to product an accurate and complete directory. Our thanks in advance.

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In the event of a change of address or failure to receive THE JOURNAL regularly, fill out this coupon and mail at once to:

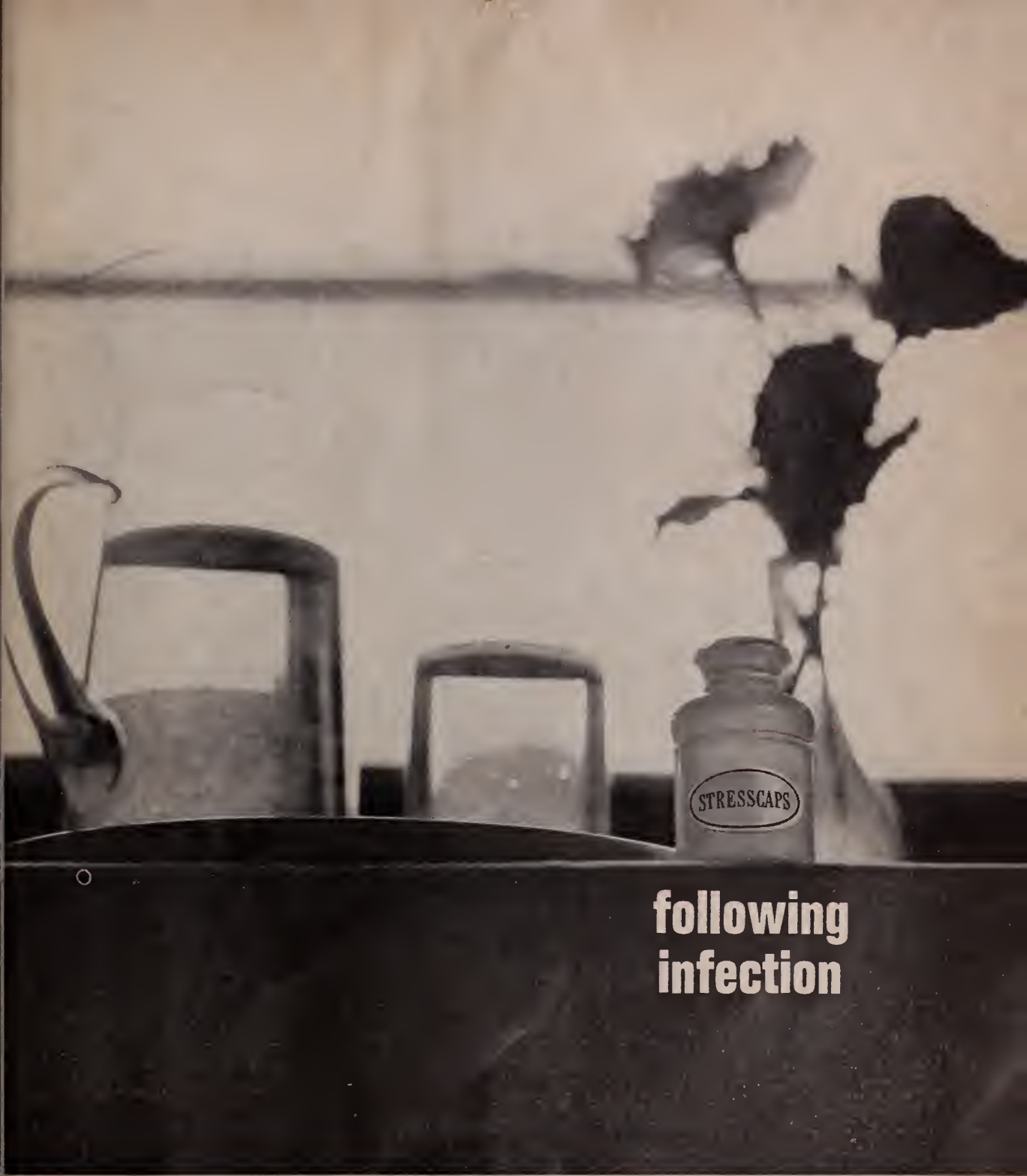
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following infection

STRESSCAPS B and C vitamins in therapeutic amounts...help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS.

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

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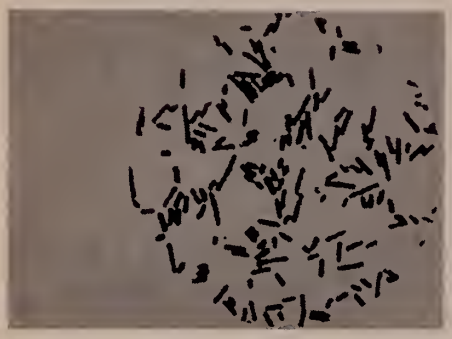
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LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY Pearl River, N.Y.

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Lederle

positive thinking about gram-negatives



Think of NegGram, the specific anti-gram-negative.

In adults two 500 mg. NegGram Caplets® orally four times a day for one or two weeks will control most gram-negative urinary infections... including many that have proved resistant to other anti-infective agents. NegGram works without causing crystalluria, fungal overgrowth, nephrotoxic or ototoxic effects. Quickly... effectively...with low risk of side effects.

Gram-negative urinary infection —cystitis, pyelitis, pyelonephritis, prostatitis, urethritis? Start first with NegGram.

treat the source with optimal dosage



NegGram®

Brand of

nalidixic acid

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1,000.

250 mg. for children, available in bottles of 56 and 1,000.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

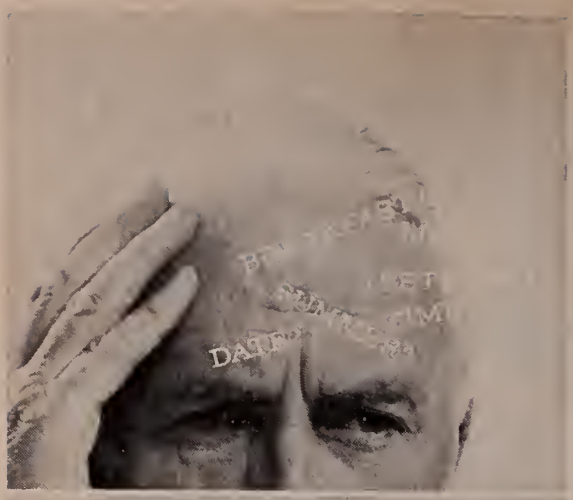
Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

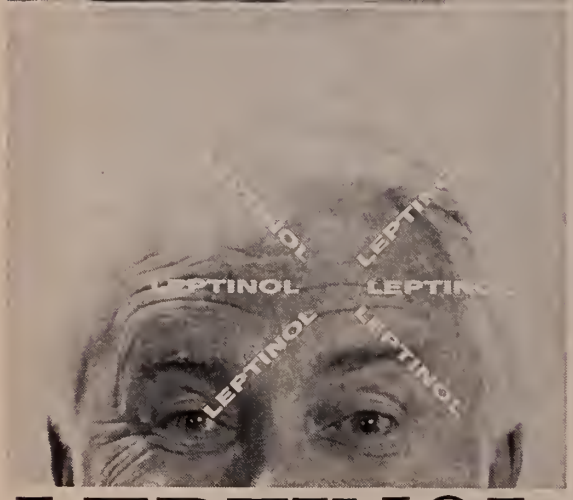
Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

WALLACE LABORATORIES
Cranbury, N.J.

CM-5761





LEPTINOL

TRADE MARK

When elderly patients display symptoms of apathy, mental confusion, memory lapses... consider LEPTINOL

Leptinol is a useful medication that deters senile mental deterioration by stimulating the cerebral vasomotor and respiratory centers . . . increasing pulmonary ventilation and the supply of blood and oxygen to the brain.

Non-addicting Leptinol also is valuable in long-term treatment, since patients do not establish a tolerance.

Each LEPTINOL bi-layer tablet contains: PENTYLENETETRAZOL, 100 mg., NIACIN, 50 mg., THIAMINE HYDROCHLORIDE, 1 mg., ASCORBIC ACID, 20 mg. DOSE: one or two tablets, 3 times daily. Leptinol produces such a sense of well-being, patients should be cautioned not to exceed recommended dose which offers maximum effectiveness.

Side Effects:—overdosage may produce tremor, convulsions or respiratory paralysis.

Caution should be taken when treating patients with a low convulsive threshold.

Write for detailed literature and starter Leptinol doses.

Vale

THE VALE CHEMICAL COMPANY, INC.

Pharmaceuticals — Allentown, Pa

Description: Hygroton, brand of chlorthalidone, is an oral diuretic agent of value in the treatment of edema and hypertension. The drug is notable for its prolonged action (48-7 hours) and low toxicity. It is n a thiazide and may often be employed successfully in patients who are intolerant of other agents or become refractory to them.

Indications: Hypertension an many types of edema involving retention of salt and wate

Contraindications: Hypersens tivity and most cases of seve renal or hepatic disease.

Warning: With administration of enteric-coated potassium supplements, the possibility small bowel lesions should b kept in mind.

Precautions: Reduce dosage of concomitant antihyperten sive agents by at least one-ha Discontinue if the BUN rises liver dysfunction is aggravate Electrolyte imbalance and po tassium depletion may occur take special care in cirrhosis or severe ischemic heart disease, and in patients receivi corticosteroids, ACTH, or dig talis. Salt restriction is not recommended.

Side Effects: Agranulocytosis constipation, dizziness, dysuria, headache, hyperglycemi hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotensio purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.

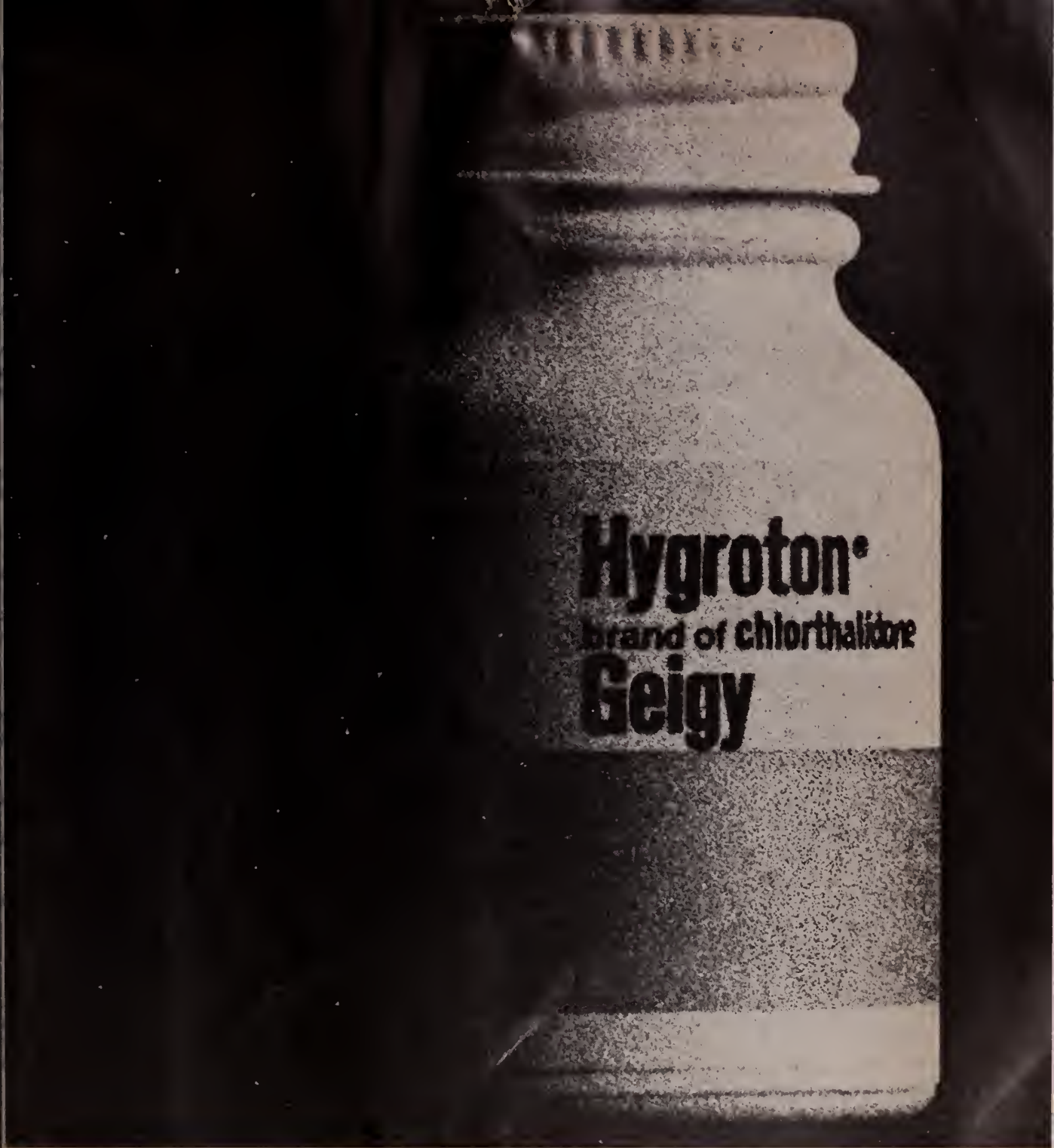
Average Dosage: One tablet (100 mg.) daily with breakfast

Availability: Tablets of 100 m in bottles of 100 and 1000. Fo full details, see the complet prescribing information.

Hygroton®

brand of chlorthalidone

The long-acting diuretic



who needs it?

Patients with edema.
Edema in congestive heart failure.
Or in the premenstrual syndrome.
Edema in pregnancy...or obesity.
Patients you want to bring to dry weight.
And those you want to keep at dry weigh
Those you want on single daily doses.
And those requiring even fewer doses.
Those resistant to other therapy.
And those intolerant of other diuretics.
Those who have to pinch pennies.
And those who can afford the best.

CLASSIFIED ADVERTISEMENTS

HOUSE PHYSICIANS—6 required for immediate openings. Accredited voluntary 375 bed general hospital located in the metropolitan area. $600 per month plus maintenance. Send resume to Medical Director of St. Mary Hospital, Hoboken, New Jersey—SW 2-3300.

INTERNIST—To join large general practice in northern New Jersey. $12,000 to $18,000 salary first year, depending on qualifications. Partnership after. Unopposed. Fully equipped new office. Write Box No. 120, c/o THE JOURNAL.

INTERNIST—Board eligible, age 31. Military service completed 7/66. One year cardiology. Interested in forming association or group in New Jersey. Write Box No. 191, c/o THE JOURNAL.

MEDICAL DIRECTOR ASSISTANT—Top voluntary health agency. Permanent position. MD interested in post graduate education and training. Internist with clinical experience preferred. Full range of benefits including excellent retirement plan. Headquartered in New York City. Curriculum vitae to: Box No. 192, c/o THE JOURNAL.

OBSTETRICIAN-GYNECOLOGIST—Military and board requirements completed, subspecialty, training in gynecological cancer. Seeks opportunity for solo, partnership, or association in the New York, New Jersey, Connecticut area, within traveling distance of New York City. Beginning July 1966. Write Box No. 191, c/o THE JOURNAL.

OBSTETRICIAN-GYNECOLOGIST—Board certified. Age 33. University trained. Family. Wishes to relocate in New Jersey with group. Write Box No. 193, c/o THE JOURNAL.

PEDIATRICIAN-GENERAL PRACTITIONER—Office space available in new colonial professional building, adequate parking for 50 cars. Located on main thoroughfare, near business district but in residential zone. Area of several thousand people, no practicing medical physician. Write Walter H. Zuber, D.D.S., 9 Greenwood Drive, Millington, New Jersey. 201-647-1588.

WANTED—Allergist, neurologist, psychiatrist, ophthalmologist, and otolaryngologist . . . to complete a medical facility consisting of specialists in private practice in an ideal community which is in great need of their services. Write: Medical Park, 1474 State Highway 23, Wayne, New Jersey.

FOR SALE—Doctor's home-office building, 10 rooms, lot 50′ x 165′. Concrete drive, 3-car garage, excellent location. For private or group practice. Office equipment optional. Schools, churches, buses, shopping center all within easy walking distance. Large general hospital 5 minute drive. Dr. Charles I. Silk, 236 High Street, Perth Amboy, New Jersey. Phone: VA 6-3351.

WANTED—Physician, surgical industrial clinic, Northern New Jersey. Full-time, regular hours. Surgical experience preferred. Good working conditions, excellent benefits. Send resume. Write Box No. 183, c/o THE JOURNAL.

WANTED—Psychiatrist, experienced, with primary interest hospital work. Many fringe benefits. Central Connecticut, near universities, in area with high cultural level. V. Gerard Ryan, M.D., 25 Marlborough Street, Portland, Connecticut.

FOR SALE IRVINGTON—Established practice, physician retiring. Four-room professional suite with private entrance and seven room apartment. Impressive corner, very accessible. House, equipment, and lucrative practice. Older type home but well kept; everything for $31,500! Write Box No. 190, c/o THE JOURNAL.

FOR SALE—Two family brick. Presently occupied by EENT man. Seven room office (may be divided), six room apartment. Prominent doctor's row; new high-rise luxury apartments nearby; hospitals available; excellent transportation. Hudson County. Write Box No. 195, c/o THE JOURNAL.

COLONIAL PROFESSIONAL BUILDING—Sudden expansion of population area creates need for obstetrician and internist. Location available opposite new 37-acre Kennedy Memorial Hospital, Edison, New Jersey. Have pediatrician and dermatologist. Also space available for ideal radiologic layout. Reserved parking for tenants and patients. All utilities, air-conditioning, building maintenance, elevator service. Telephone Dr. Morris Weiner, 201-388-1245.

FOR RENT—Suite in small professional building, street floor, air-conditioned, off-street parking. Centrally located in South Orange, New Jersey. Suite #1—730 square feet. Suite #2—450 square feet. 201-AD 3-1901.

FOR RENT—Medical office, ideal for pediatrician or surgical specialty. 620 square feet, remaining in new air-conditioned, one story building, downtown Red Bank, off-street parking. Occupancy June 1, 1966. Building will be occupied by two internists and a dermatologist. Call 201-741-1068.

CUSTOM OFFICE FOR LEASE—Vacancy for ophthalmologist, psychiatrist, EENT man open. 900 square feet, Colonial air-conditioned building. Interior construction erected to desire of tenant. Nearby new hospital building. Community Medical Arts Building, West Maple and Church Street, Bound Brook, New Jersey.

HAS DRINKING BECOME A PROBLEM?—The medical professional group of alcoholics anonymous meets first and third Saturday. Phone BI 2-1515; or write Secretary, Box 342, Woodbridge, New Jersey.

Information for Advertisers—RATES: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, **c/o THE JOURNAL**" as six words. **COPY DEADLINE:** Thirteenth of preceeding month.



the difference between cough and relief

Benylin® Expectorant

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5 per cent alcohol.

for relief of coughs due to colds or allergy

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers, if used with BENYLIN EXPECTORANT, should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT. PACKAGING: Bottles of 4 oz., 16 oz., and 1 gallon.

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PARKE, DAVIS & COMPANY, Detroit, Michigan 48232



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The Somatic Mask: chest pain— heart disease or psychic tension?

Precordial pain as well as tachycardia, palpitation, breathlessness and faintness or arrhythmias are classic signs of cardiac disease. In many cases, however, they may represent a "somatic mask"—a psychophysiological equivalent of psychic tension.

Valium (diazepam) reduces the patient's disturbing psychic tension and helps improve such related symptoms as sadness and feelings of hopelessness, fatigue, insomnia, crying spells and nervousness.

In prescribing: Dosage — Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal of hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Supplied: Tablets, 2 mg, 5 mg and 10 mg; bottles of 50.

Valium® (diazepam)

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

The New York Academy of Medicine

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NOT RENEWABLE AFTER 6 WEEKS

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